

16026

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16018

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 2 WEEKS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS 2 VERMONT ST.	
3. NAME OF DECEASED (Type or print) First Middle Last FRANK EUGENE ARDINGER		4. DATE OF DEATH Month Day Year NOVEMBER 4, 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/18/1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 71
11. BIRTHPLACE (County & State, or foreign country) WASHINGTON CO. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES ALBERT ARDINGER		14. MOTHER'S MAIDEN NAME MARY CATHERINE GRUBER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT 2 VERMONT STREET ARIE A. ARDINGER WILLIAMSPORT, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of Liver 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cholelithiasis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 1/2 months Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Regional Electric; Obesity; Epigenous; Distal Myelitis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. DECEASED WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour :m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 1953 to Nov. 4, 1967 , that (I) (we) last saw the deceased alive on Nov. 4, 1967 , and that death occurred at 3:30 A.M. from causes and on the date stated above.			
22a. SIGNATURE Dalton M. Welty		22b. DATE SIGNED 11-6-67	
22c. PHYSICIAN'S NAME (Type) Dalton M. Welty, M.D.		22d. ADDRESS 998 Potomac Ave., Hagerstown, Md. 21740	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 11/6/67	23c. NAME OF CEMETERY OR CREMATORIUM RIVERVIEW CEMETERY	23d. LOCATION (City or Town) (County) (State) WILLIAMSPORT, WASH., MD.
24. FUNERAL DIRECTOR Howard F. Stone		25a. REC'D BY REGISTRAR NOV 9 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

NAME: CHAYAN

ADDRESS:

TELEPHONE:

DATE:

TIME:

AGE:

SEX:

WEIGHT:

HEIGHT:

HAIR:

EYES:

SKIN:

TEETH:

DIAGNOSIS:

TREATMENT:

PROGNOSIS:

REMARKS:

PHYSICIAN:

HOSPITAL:

NO.

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DATE:

LOCATION:

REMARKS:

PHYSICIAN:

HOSPITAL:

DATE:

TIME:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 55 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 300 S. CANNON AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First DAVID Middle WALTER Last BAKER					4. DATE OF DEATH Month NOVEMBER Day 21 Year 1967				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 7/30/1901		9. AGE (In years last birthday) 66 yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CARPENTER			10b. KIND OF BUSINESS OR INDUSTRY RAIL ROAD			11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVID CLINTON BAKER					14. MOTHER'S MAIDEN NAME MARGARET MAY MINER				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 212-24-5744		17. INFORMANT Address HAGERSTOWN MRS. MARGARET L. ROHRER MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of Liver 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis of Liver								INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Nov. 12, 1967 to Nov. 21, 1967 that (I) (we) last saw the deceased alive on Nov. 18, 1967 , and that death occurred at 6:45 P.M. from causes and on the date stated above.									
22a. SIGNATURE J. H. Beachley MD					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Nov. 21/67		
22c. PHYSICIAN'S NAME (Type) J. H. Beachley MD					22d. ADDRESS Hagerstown, Md.				
23a. BURIAL, CREMATION, REINTERMENT BURIAL		23b. DATE THEREOF 11/24/67		23c. NAME OF CEMETERY OR CREMATORY LEITERSBURG LUTHERN		23d. LOCATION (City or Town) (County) (State) LEITERSBURG WASH. MD.			
24. FUNERAL DIRECTOR W. T. Harment, Hagerstown, Md.					25a. REC'D BY REGISTRAR DATE NOV 27 1967		25b. REGISTRAR'S SIGNATURE Charles J. Suss		

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NOTICE

CHARTER

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VR A15 (4)
20M 5-63

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>																						
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural, Hagerstown, Md.</u> c. LENGTH OF STAY IN 1b <u>one month</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Martin Manor Nursing Home</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>Berkeley</u> ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Martinsburg, West Virginia</u> d. STREET ADDRESS <u>309 West Burke Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																
3. NAME OF DECEASED (Type or print) First <u>Willie</u> Middle <u>Haycock</u> Last <u>Baker</u>			4. DATE OF DEATH Month <u>November</u> Day <u>23</u> Year <u>1967</u>			5. SEX <u>Female</u>			6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>											
8. DATE OF BIRTH <u>29 May 1878</u>			9. AGE (In years last birthday) <u>89</u> yrs. <table border="1"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>			IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Frederick county, Virginia</u>		
IF UNDER 1 YEAR		IF UNDER 24 HRS.																				
Months	Days	Hours	Min.																			
12. CITIZEN OF WHAT COUNTRY <u>USA</u>						13. FATHER'S NAME <u>Charles M. Haycock</u>			14. MOTHER'S MAIDEN NAME <u>Virginia M. (unknown)</u>													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT <u>Donald J. Roach</u> Address <u>402 Lincoln Drive Martinsburg W. Va.</u>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Occlusion - due</u> <u>4201</u> DUE TO <u>Advanced Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (b) <u>with congestive failure.</u> (a), stating the underlying cause last. DUE TO <u>General Arteriosclerosis</u> (c) <u>Diverterculosis - Colon</u>			INTERVAL BETWEEN ONSET AND DEATH <u>25 yrs</u> <u>25-30 yrs</u>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diverterculosis - Colon</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)											
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 12, 1967</u> to <u>Nov 23, 1967</u>, that (I) (we) last saw the deceased alive on <u>Nov 19, 1967</u>, and that death occurred at <u>12:15 P.M.</u> from the causes and on the date stated above.																						
22a. SIGNATURE <u>Edward W. Ditto III</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>11-24-67</u>													
22c. PHYSICIAN'S NAME (Type) <u>Edward W. Ditto 111 M.D.</u>						22d. ADDRESS <u>217 W. Washington St. Hagerstown, Maryland</u>																
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>25 Nov. 1967</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Rosedale cemetery</u>			23d. LOCATION (City, town or county) <u>Martinsburg, W. Va.</u>													
24. FUNERAL DIRECTOR'S SIGNATURE <u>Donald Seckler</u> ADDRESS <u>Harpers Ferry, W. Va.</u>						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <u>John L. Judge</u>													
DATE <u>NOV 28 1967</u>																						

10053



[Faint, mostly illegible text covering the page, possibly bleed-through from the reverse side. Some words like "REPORT", "DATE", and "BY" are faintly visible.]

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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1. PLACE OF DEATH o. COUNTY Washington MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro c. LENGTH OF STAY IN 5 Mos d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fahrney- Keedy Home				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 43 East Longmeadow Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) URA KATHRYN BARNHART First Middle Last 4. DATE OF DEATH November 5 1967 19 Month Day Year				5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Sept 2 1889 9. AGE (In years last birthday) 78 yrs. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hotel Employee		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Cavetown Wash Co Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David S. Barnhart				14. MOTHER'S MAIDEN NAME Margaret V. Fry			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) -----		16. SOCIAL SECURITY NO. 050-10-2872		17. INFORMANT Mr Harvey Miller Hagerstown Md Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia R # 4 1810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Bladder DUE TO (c) 4 months						INTERVAL BETWEEN ONSET AND DEATH 4 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/4 , 19 65 to 10/9 , 19 67 , that (I) (we) last saw the deceased alive on 10/9 , 19 67 , and that death occurred at 4:20 PM , from causes and on the date stated above.							
22a. SIGNATURE Donald E. Martin, M.D.				22b. DATE SIGNED 11/6/67		22c. PHYSICIAN'S NAME (Type) Donald E. Martin, M.D.	
22d. ADDRESS 418 N. Potomac St., Hagerstown, Md.				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/8/67		23c. NAME OF CEMETERY OR CREMATORY Lutheren Cemetery		23d. LOCATION (City or Town) (County) (State) Leitersburg Wash Co Md	
24. FUNERAL DIRECTOR Hagerstown Md ADDRESS Andrew K. Coffman Funeral Home Inc				25a. REC'D BY REGISTRAR NOV 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Maryland</u>	
c. LENGTH OF STAY IN TB <u>68yrs</u>		d. STREET ADDRESS <u>646 Pennsylvania Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>646 Pennsylvania Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lewis Edward Bell</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>11</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-18-1894</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Beavercreek, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Bell</u>		14. MOTHER'S MAIDEN NAME <u>Hattie Adams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>213-12-7647</u>	
17. INFORMANT <u>Mrs Thelma Slaughter</u>		Address <u>646 Penn Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Atherosclerotic Heart Disease</u> DUE TO <u>and Hypertensive Cardiovascular Disease</u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>7yrs 11mth</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>January</u> , 19 <u>59</u> , to <u>Nov 11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov 4</u> , 19 <u>67</u> , and that death occurred at <u>4:45 PM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>William T. Layman, M.D.</u>		22b. DATE SIGNED <u>Nov 13, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>William T. Layman, M.D.</u>		22d. ADDRESS <u>100 Professional Arts Bld. Hagerstown.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov 15 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Maryland</u>
24. FUNERAL DIRECTOR <u>John R Watson Jr Hagerstown Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 14 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>James Judge</u>		25c. REGISTRAR'S NAME <u>James Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

6202

CHRYSLER CREDIT

12/2/71

Dear Sir:

RE: [illegible]

RE: [illegible]

Local Government [illegible]

Administrative [illegible]
and Representative [illegible]

Very truly,
Yours,


William J. Lawrence

cc: [illegible]

cc: [illegible]

cc: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form FM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16031

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16023

1 PLACE OF DEATH a COUNTY Washington MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution b STATE West Virginia c COUNTY Berkeley Residence before admission)			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Martinsburg			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hospital				e STREET ADDRESS Route 3			
3 NAME OF DECEASED (Type or print) First Samuel Middle Eugene Last Bender				4 DATE OF DEATH Month November Day 25 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH March 30, 1949		9 AGE (in years lost birthday) 18 yrs	10 UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b KIND OF BUSINESS OR INDUSTRY College		11. BIRTHPLACE (State or foreign country) Martinsburg, W. Va.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Samuel O. Bender				14 MOTHER'S MAIDEN NAME Lola Pierce			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16 SOCIAL SECURITY NO No		17. INFORMANT Address Samuel O. Bender-Rt. 3, Martinsburg, W. Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DEPRESSED FRACTURE OF SKULL DUE TO (b) FRACTURE RIGHT WRIST DUE TO (c) FRACTURE LEFT CLAVICLE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH 4HRS.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) CAR LEFT ROAD STRIKING UTILITY POLE					
20c TIME OF INJURY Month, Day, Year 7:30 PM 11-25-67		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) U.S. ROUTE 11		20f (City or town) (County) (State) MARTINSBURG, W. VA.		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Dr. E.W. Ditto, Jr.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 11-26-67	
EXAMINER'S NAME (Type) DR. E.W. DITTO, JR.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)	
23a BURIAL, CREMATION REMOVAL (Specify) Burial	23b DATE THEREOF 11-28-1967	23c NAME OF CEMETERY OR CREMATORY Rosedale Cemetery		23d LOCATION (City or Town) (County) (State) Martinsburg Berkeley, W. Va.			
24 FUNERAL DIRECTOR N.N. Brown		ADDRESS Brown Funeral Home - Martinsburg, W. Va.		25a REC'D BY REGISTRAR NOV 28 1967		25b REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

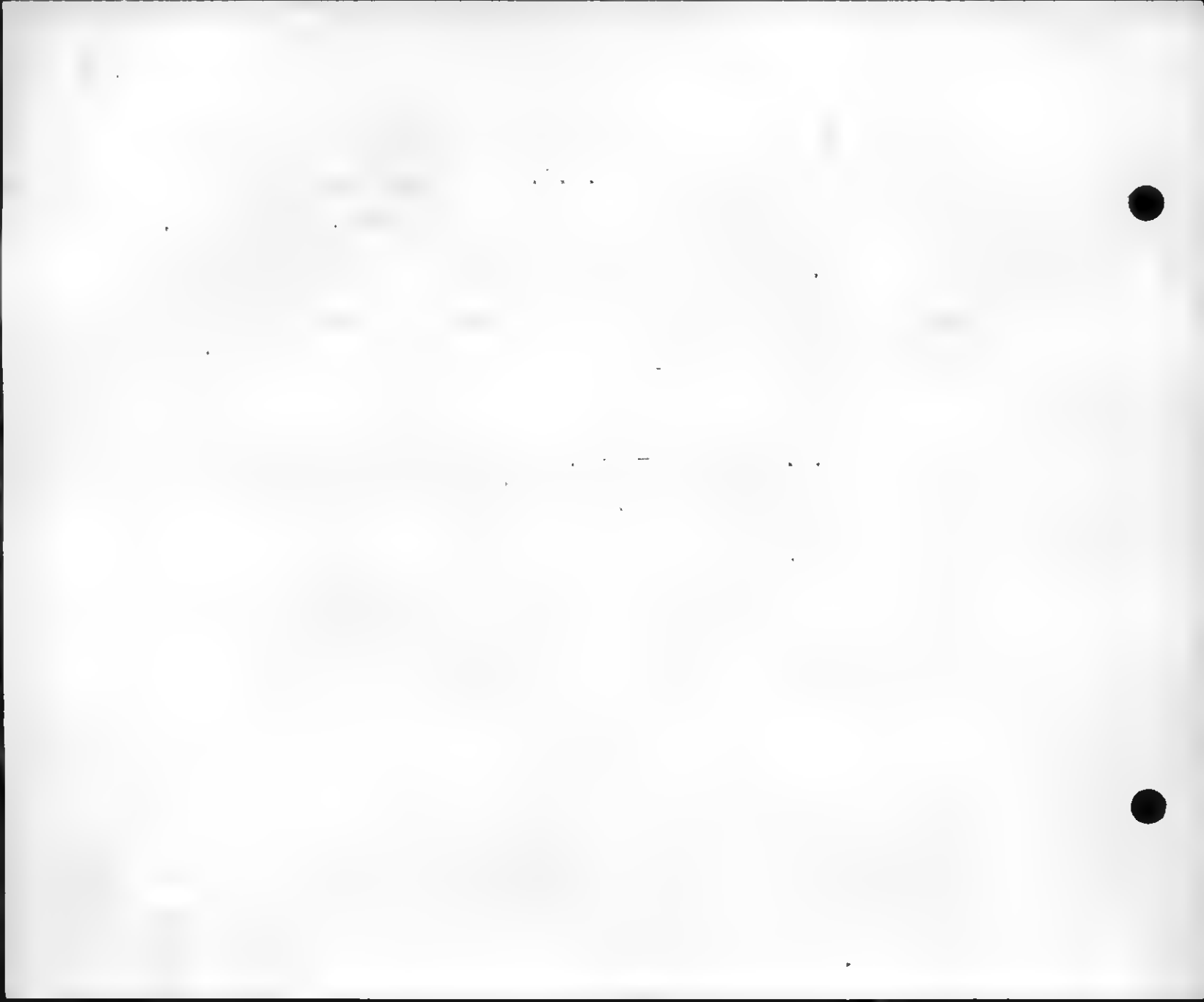
CERTIFICATE OF DEATH

16032

16024

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN IT D.O.A.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 1606 Broadfording Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Rev. Chester Adam Billman				4. DATE OF DEATH Month Day Year Nov 25 1967 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 19 1894	
9. AGE (In years last birthday) 73 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clergyman		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (County & State, or foreign country) Pa. Shamokin Northumberland Co	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Frank Billman			
14. MOTHER'S MAIDEN NAME Ida McCarty				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W.#1			
16. SOCIAL SECURITY NO. 216-14-8171		17. INFORMANT Address Mrs Frances MoC Billman Md				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Arterio-sclerotic heart disease DUE TO (b) 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 4200	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1960 , to Nov 25 , 19 67 , that (I) (we) last saw the deceased alive on 24 Nov 19 67 , and that death occurred at 6:30 AM , from causes and on the date stated above.							
22a. SIGNATURE E. Don S. Hoachler M.D.				22b. DATE SIGNED 11/27/67		22c. PHYSICIAN'S NAME (Type) E. Don S. Hoachler Hagerstown Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/28/67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR Hagerstown Md Andrew K. Coffman Funeral Home Inc				25a. REC'D BY REGISTRAR NOV 28 1967		25b. REGISTRAR'S SIGNATURE Theresa Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				16033				16025			
CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u>				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN 1b <u>10 mon. 17 days</u>				2. USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE <u>Maryland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Williamsport Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				b. COUNTY <u>Washington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hancock</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarence Henry Bivens</u>				4. DATE OF DEATH Month Day Year <u>11 17 1967</u>				5. SEX <u>MALE</u>				6. COLOR OR RACE <u>White</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>3-16-86</u>				9. AGE (In years last birthday) <u>81</u> yrs.				10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Franklin County, PA.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Paul Bivens</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Jane Taylor</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-32-4739-A</u>			
17. INFORMANT <u>VADA BIVENS HANCOCK MD.</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Pneumonia etiology unknown</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>—</u> DUE TO (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Atherosclerosis</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc)				20f. (City or town) (County) (State)				21. I certify that (1) (this hospital) attended the deceased from <u>1/31/1967</u> , to <u>11-17</u> , 1967, that (1) (we) last saw the deceased alive on <u>11-10</u> , 1967, and that death occurred at <u>—</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>M.E. Byrkit</u>				22b. DATE SIGNED <u>11-17-67</u>				22c. PHYSICIAN'S NAME (Type) <u>M.E. Byrkit</u>				22d. ADDRESS <u>Williamsport Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>11.20.67</u>				23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR LAWN MEMORIAL</u>				23d. LOCATION (City or Town) (County) (State) <u>HAGERSTOWN WASHINGTON MD.</u>			
24. FUNERAL DIRECTOR <u>Howard J. Glone Hancock md</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 21 1967</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10726

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE PA b. COUNTY FRANKLIN			
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN TB 18 HRS		c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) RURAL GREENCASTLE PA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON CO HOSPITAL HAGERSTOWN MD				d. STREET ADDRESS RD # 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Richard Eugene BLACK				4 DATE OF DEATH Nov. 23, 1967			
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Aug. 28, 1949	9 AGE (In years, last birthday) 18	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or give if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY School		11 BIRTHPLACE (State or foreign country) Waynesboro, Pa.		12 CITIZEN OF WHAT COUNTRY U.S.A.	
13 FATHER'S NAME Robert E. BLACK				14. MOTHER'S MAIDEN NAME Iva Hager			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, name unknown) No		16 SOCIAL SECURITY NO 175-40-1369		17 INFORMANT Robert E. Black - Greencastle Pa		Address PA1	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of blood and vomitus 1234 DUE TO Pulmonary congestion and edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture (comminuted) for maxilla and DUE TO Fracture of mandible (c) _____						INTERVAL BETWEEN ONSET AND DEATH 18 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Car left road, crashing into embankment					
20c. TIME OF INJURY Month Day, Year 2:40 a.m. Nov. 23 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) US Rt. 11		20f. (City or town) (County) (State) Greencastle/Franklin/Pa.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE E. W. DITTO, JR. M.D.				22. DATE SIGNED Nov. 24, 1967			
EXAMINER'S NAME (Type) E. W. DITTO, JR., M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REBURY (Specify) B.		23b. DATE THEREOF 11/26/67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION (City or town) (County) (State) Greencastle Pa.	
24. FUNERAL DIRECTOR A. E. Minnich - Greencastle, Pa.				25a. REGISTERED NOV 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

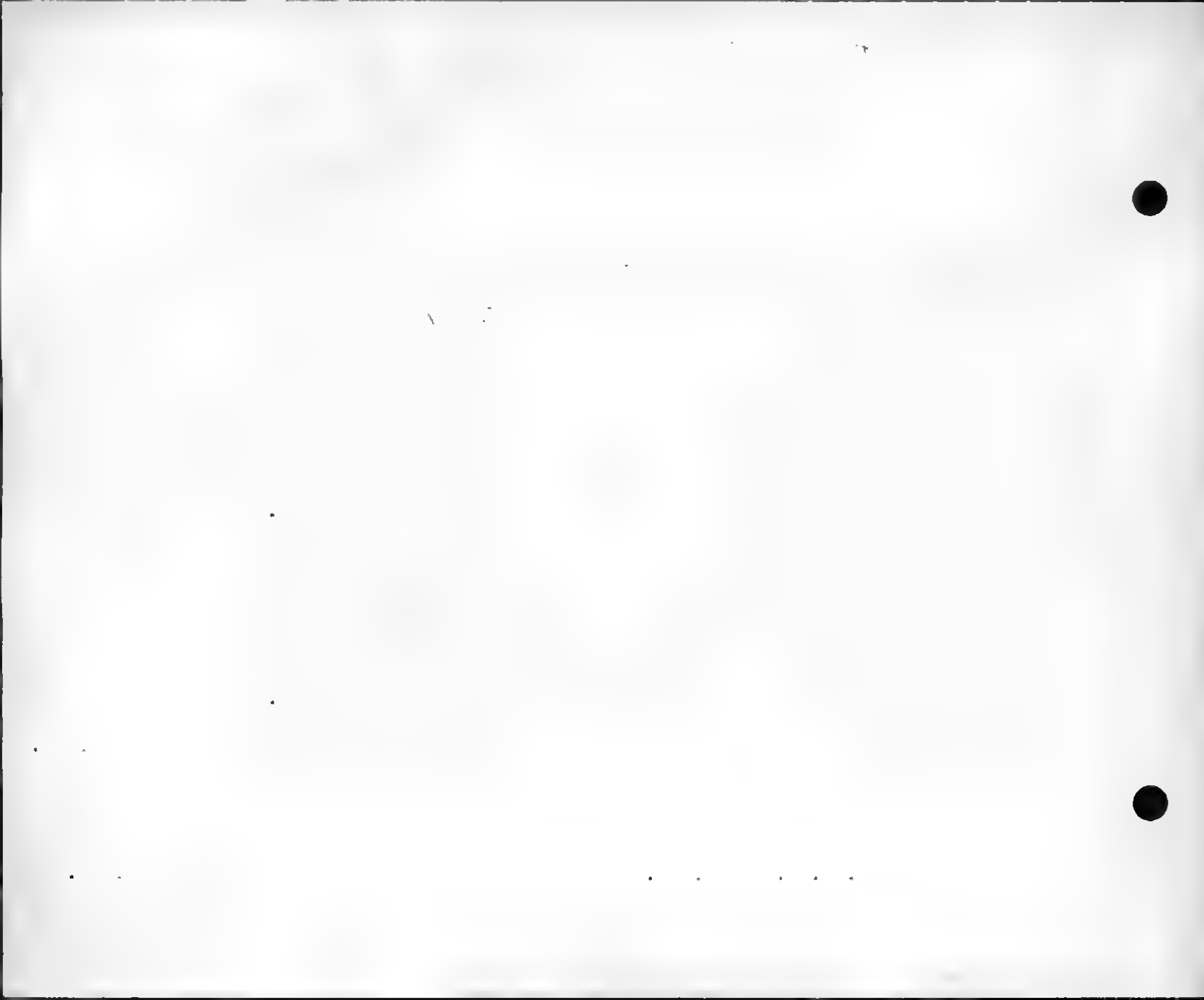
VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16027

1. PLACE OF DEATH a COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Washington		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland			c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 112 N. Jonathan Street			d STREET ADDRESS 112 N. Jonathan Street		
3. NAME OF DECEASED (Type or print) Richard Victor Boggison			4. DATE OF DEATH Month Nov Day 3 Year 1967		
5 SEX Male	6 COLOR OR RACE Colored	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 10/12/92	9 AGE (In years last birthday) 75 yrs	10 UNDER 1 YEAR Months 0 Days 0
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b KIND OF BUSINESS OR INDUSTRY Shoe shine		11 BIRTHPLACE (State or foreign country) Charles Town W. Va.	
13 FATHER'S NAME Richard Boggison			14 MOTHER'S MAIDEN NAME Lettie Tryman		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 214-14-6939		17 INFORMANT Lenora B. Crew Address 412 N. Jonathan St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head self inflicted. DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH Instant
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Self inflicted gunshot wound of head.			
20c TIME OF INJURY Month Day, Year 10 p.m. 11-2-19 67		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f (City or town) Hagerstown, Washington, Md.		20g (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE H. E. W. Ditto, Jr.		M.D.		22. DATE SIGNED 11-6-67	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/> DEPUTY MFD CAL. EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) Hagerstown, Md.			
23a BURIAL CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF Nov 7 1967	23c NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d LOCATION (City or town) (County) (State) Hagerstown Maryland	
24 FUNERAL DIRECTOR John R Watson Jr Hagerstown Md		ADDRESS		25a REC'D BY REGISTRAR NOV 7 1967	
				25b REGISTRAR'S SIGNATURE Charles Juggins	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

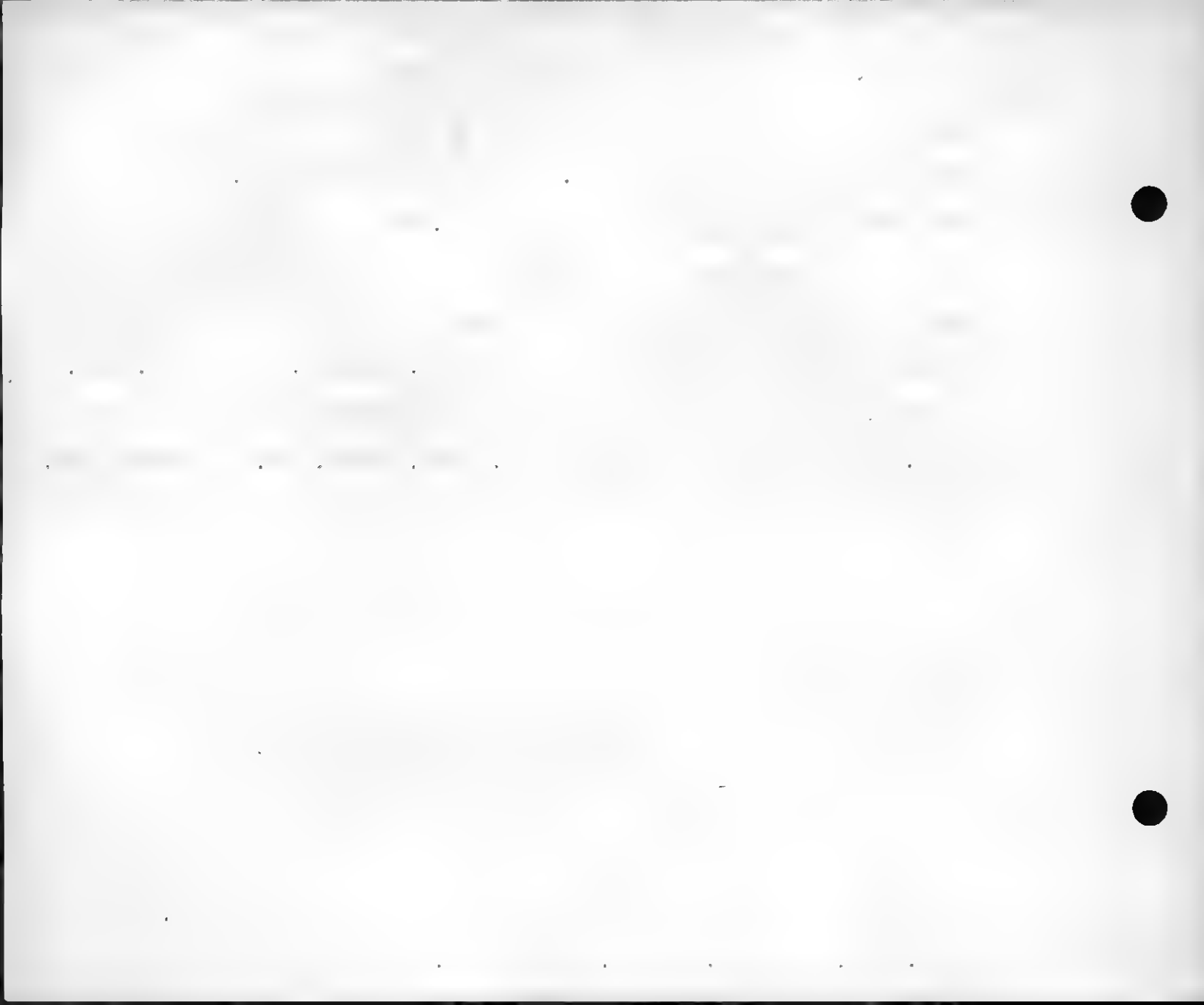
16036

16028

1 PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 6 Hrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS Mt. Lena			
3 NAME OF DECEASED (Type or print) First Middle Last Charles Hott Bowman				4. DATE OF DEATH Month Day Year November 14, 1967			
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 13, 1890	9 AGE (In years last birthday) 77 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Mt. Lena, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME David Bowman				14. MOTHER'S MAIDEN NAME Louise Faulder			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO 212-24-5385		17. INFORMANT Address Mr. Ira G. Bowman, Rfd. 2, Boonsboro, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarct 4401 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 12 hours years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Squamous cell carcinoma of bladder						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port I of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-25 , 19 62 , to 11-14 , 19 67 , that (I) (we) lost saw the deceased alive on 11-14 - 19 67 , and that death occurred at 5:22 P.M. from causes and on the date stated above.							
22a. SIGNATURE <i>Joseph Secondary</i>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 11-16-67	
22c. PHYSICIAN'S NAME (Type) JOSEPH SECONDARY				22d. ADDRESS BOONSBORO MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-18-67		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		23d. LOCATION (City or Town) (County) (State) Smithsburg, Md.	
24. FUNERAL DIRECTOR ADDRESS John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.				25a. REC'D BY REGISTRAR NOV 21 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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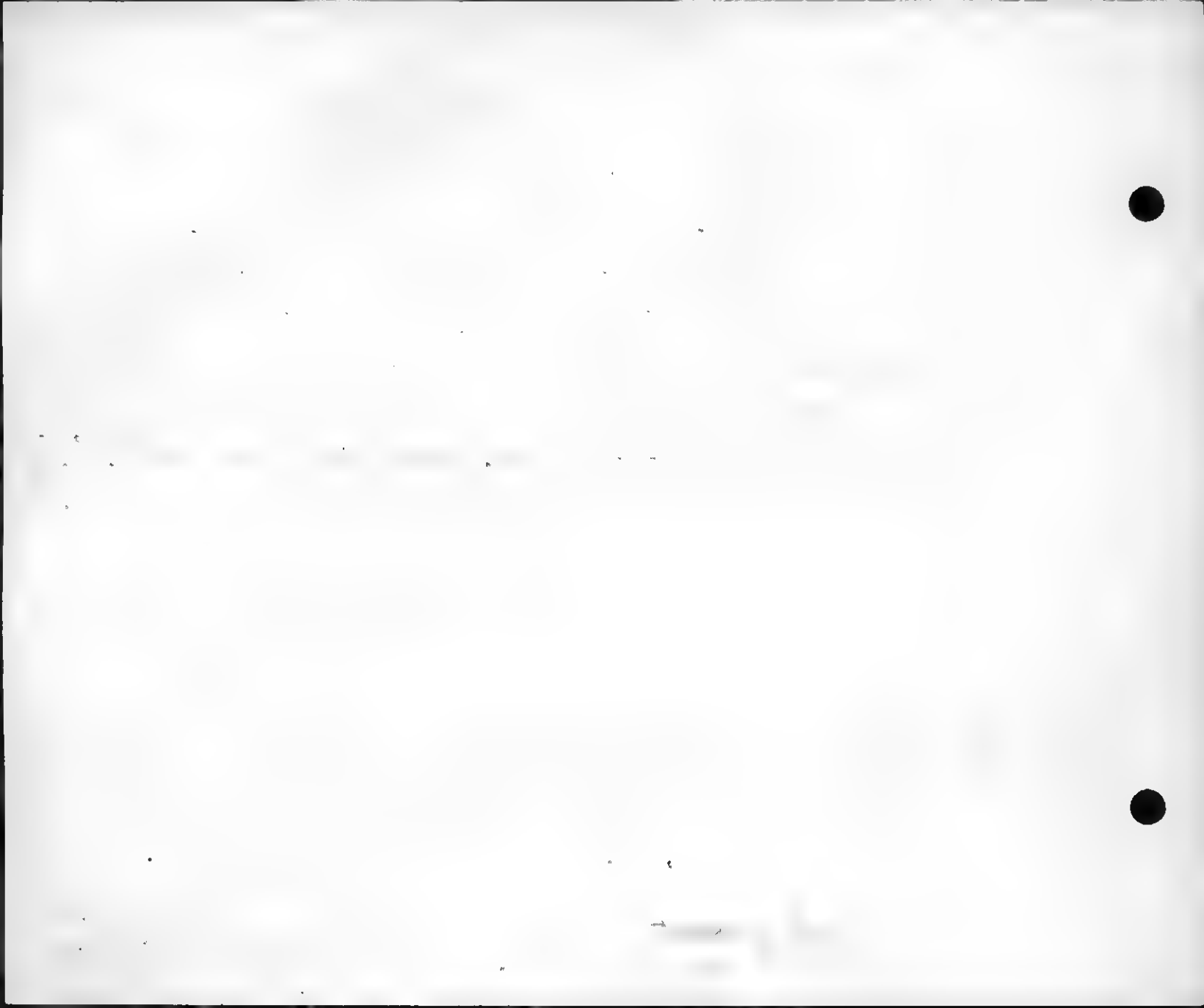
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #23d B11m #23d5 12/5/67 ph & Item #23b

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY in 1b <u>4 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1401 Haven Road Apt. 79</u>				d. STREET ADDRESS <u>1401 Haven Road Apt. 79</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>nm</u> Last <u>Buckley</u>				4. DATE OF DEATH Month <u>November</u> Day <u>30</u> Year <u>19 67</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12, 1874</u>		9. AGE (In years last birthday) <u>93</u> yrs	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Glasgow, Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David Carruthers</u>				14. MOTHER'S MAIDEN NAME <u>Margaret MacPherson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>098-10-5489B</u>		17. INFORMANT Address <u>Hagerstown, Md.</u> <u>Mrs. Margaret Jellmeth 1401 Haven Rd. Apt. 79</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Lobar Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Fractured Hip</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs. or</u> <u>1 month</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/29</u> , 19 <u>67</u> , to <u>11/29</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>11/29</u> , 19 <u>67</u> and that death occurred at <u>7:55 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Arturo N. Riego, M.D.</u>				22b. DATE SIGNED <u>11/30/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Arturo N. Riego, M.D.</u>	
22d. ADDRESS <u>119 East Antietam St. Hagerstown</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>Dec. 1, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Nassau N. Y.</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>Wm. G. Ash</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 1 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>	
Rest Haven Funeral Chapel Hagerstown, Md.							



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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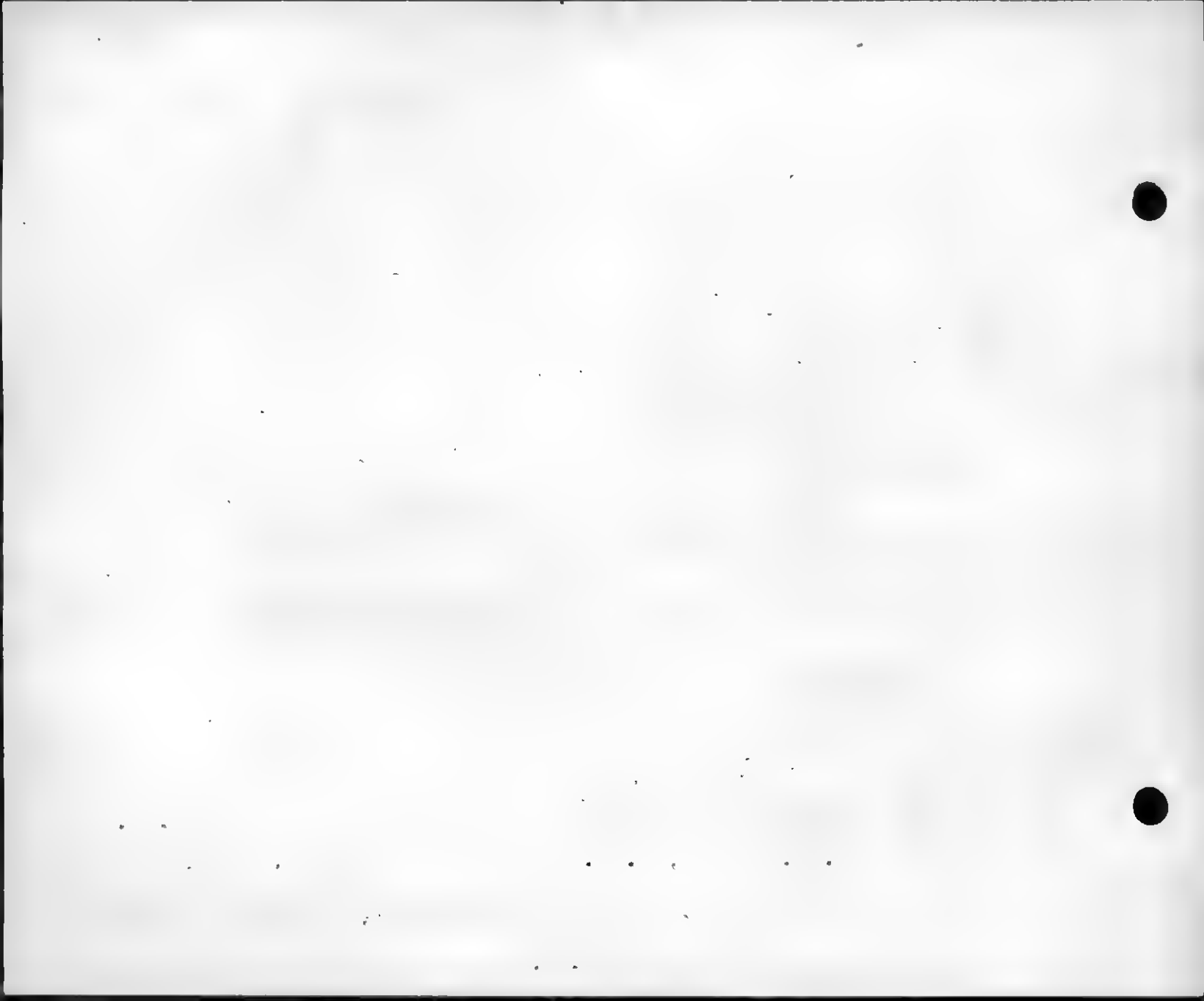
1 PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 15 MIN.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS RURAL 2	
3 NAME OF DECEASED (Type or print) First BELINDA Middle KRISTEN Last BURNETT		4 DATE OF DEATH Month 11 Day 6 Year 19 67	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 24 1967
9. AGE (In years lost birthday) 1 MO 4		IF UNDER 1 YEAR Months 2 Days WKS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) HAGERSTOWN MD		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES R BURNETT		14. MOTHER'S MAIDEN NAME ADONA BROWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT CHARLES R BURNETT		Address RURAL 2 HANCOCK MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1540 DUE TO Coronary Failure & Pulmonary edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to (c) Congenital Heart disease probably Pathology of Fetal birth		INTERVAL BETWEEN ONSET AND DEATH about 4 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/24/67 , 1967, to 11/6/67 , 1967, that (I) (we) last saw the deceased alive on 11/2 , 1967, and that death occurred at 7:35 AM , from causes and on the date stated above			
22a. SIGNATURE A.M. Bacon		22b. DATE SIGNED 11/7/67	
22c. PHYSICIAN'S NAME (Type) A.M. Bacon Jr.		22d. ADDRESS 101 King St. Hagerstown, MD	
23a. BURIAL, CREMATION, REMOVAL (Type) BURIAL	23b. DATE THEREOF 11.9.67	23c. NAME OF CEMETERY OR CREMATORY UNION E.B.	23d. LOCATION (City or Town) MORGAN (State) VA RURAL BERKELEY SPRINGS
24. FUNERAL DIRECTOR Howard J. Stone		25a. REC'D BY REGISTRAR Hancock md	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE NOV 9 1967	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if instit on Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. LENGTH OF STAY IN 1b <u>6 mos. 17 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Williamsport Sanitarium</u>		d. STREET ADDRESS <u>203 W. Burke St.</u>	
3 NAME OF DECEASED (Type or print) First <u>Sally</u> Middle <u>S.</u> Last <u>Butler</u>		4 DATE OF DEATH <u>November 6, 1967</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 4, 1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OFFICE WORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HEALTH DEPT.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Shepherdstown, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Abraham Shepherd</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>236-10-1247A</u>	
17. INFORMANT (Sister) <u>MISS LAURA Shepherd</u>		Address <u>MARTINSBURG 303 W. Burke St. W. VA</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4221 Congestive Heart Failure</u> DUE TO (b) <u>Atherosclerotic cardiac-vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>10 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 WKS</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) <u>the deceased</u> attended the deceased from <u>April 21, 1967</u> to <u>Nov 6, 1967</u> , that (1) <u>the</u> last saw the deceased alive on <u>October 23, 1967</u> , and that death occurred at <u>8 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>M. E. Byrkit</u>		22b. DATE SIGNED <u>11.13.67</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. E. Byrkit, M. D.</u>		22d. ADDRESS <u>Williamsport, Maryland 21795</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>NOVEMBER 8-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ELMWOOD CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>SHEPHERDSTOWN-JEFFERSON-W. VA</u>
24. FUNERAL DIRECTOR <u>Donald Eckles</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Harpers Ferry W. Va.</u>		DATE <u>NOV 16 1967</u>	



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13032

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>MORGAN</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERKELEY SPRINGS</u>	
c. LENGTH OF STAY in 1b <u>1 hr.</u>		d. STREET ADDRESS <u>527 S. WASHINGTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON County</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NORA</u> Middle <u>V.</u> Last <u>CAIN</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 19, 1887</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>MORGAN Co., W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ASBURY H. CROUSE</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE V. STOTLER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Mrs. Harry Hood</u>		Address <u>HANCOCK, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intracerebral Hemorrhage</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 17</u> , 1967, to <u>Nov 17</u> , 1967, that (I) (we) last saw the deceased alive on <u>Nov 17</u> , 1967, and that death occurred at <u>7 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Chas. Greener</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11-19-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>	23d. LOCATION (City or Town) (County) (State) <u>BERKELEY SPRINGS, W. Va.</u>
24. FUNERAL DIRECTOR <u>Sam B. Hunter</u>		25a. REC'D BY REGISTRAR <u>BERKELEY SPRINGS, W. Va.</u>	
25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u>		DATE <u>NOV 20 1967</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

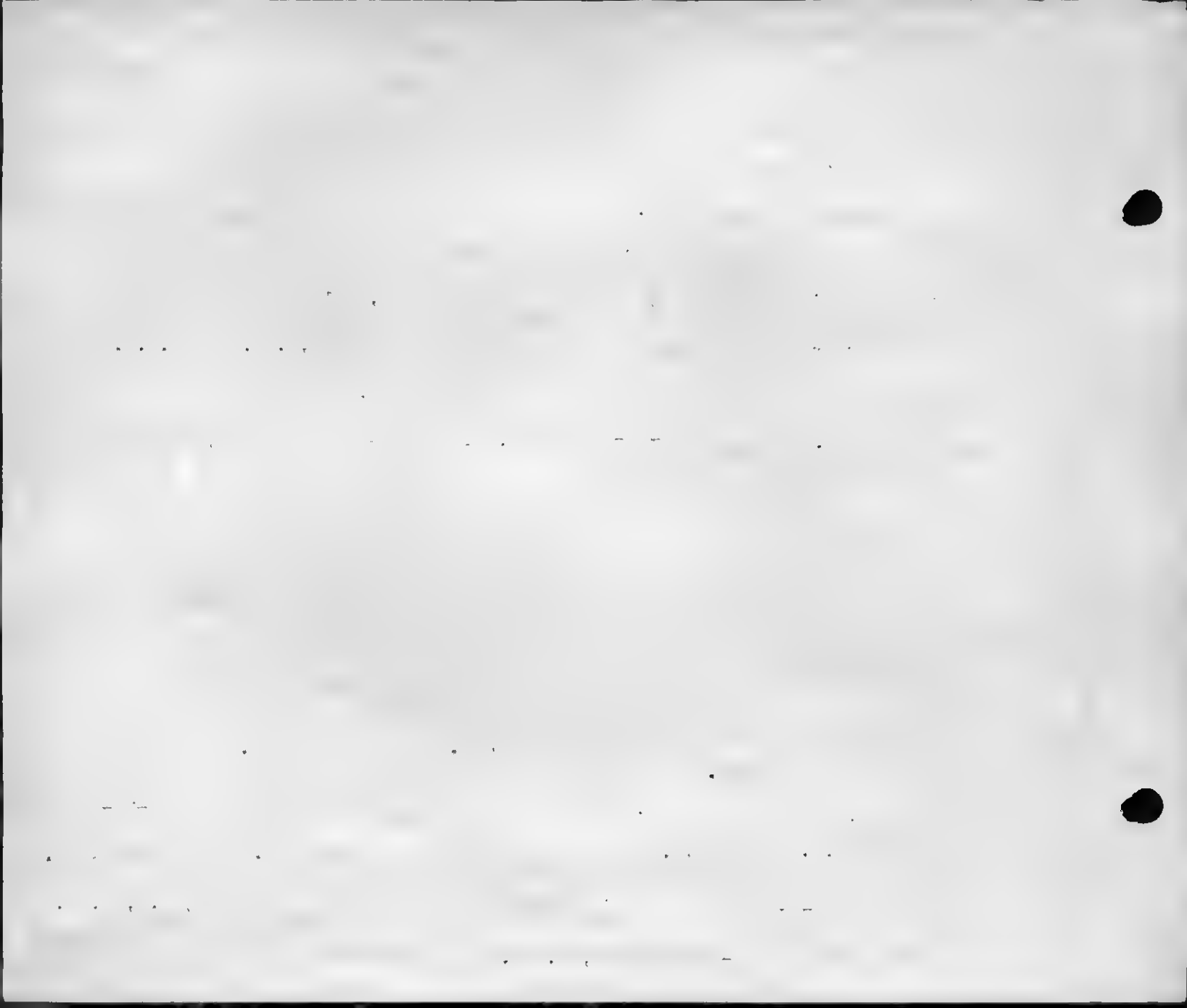
CERTIFICATE OF DEATH

1964

13033

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>Berkeley</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Falling Waters</u> d. STREET ADDRESS <u>Route 1 (Marlowed)</u>			
3. NAME OF DECEASED (Type or print) <u>Andrew</u> <u>Vernon</u> <u>Canby</u>		4. DATE OF DEATH Month <u>November</u> Day <u>27</u> Year <u>1967</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <u>September 30, 1891</u>			
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u>		IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Berkeley County, W. Va.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Samuel Canby</u>			14. MOTHER'S MAIDEN NAME <u>Harriett A. Stuckey</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>236-56-3738</u>		17. INFORMANT <u>K. C. Miller-</u> Address <u>Hagerstown, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary atherosclerosis</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (1) (this hospital) attended the deceased from <u>Jan. 1, 1959</u>, to <u>Nov. 27, 1967</u> that (1) (we) last saw the deceased alive on <u>Nov. 27, 1967</u>, and that death occurred at <u> </u> p.m., from the causes and on the date stated above.							
22a. SIGNATURE <u>M.E. Byrkit</u>		22b. DATE SIGNED <u>11-29-67</u>		22c. PHYSICIAN'S NAME (Type) <u>M.E. Byrkit M.D.</u>			
22d. ADDRESS <u>28 West Potomac St. Williamsport, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-1-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Harmony Cemetery</u>			
23d. LOCATION (City, town or county) <u>Falling Waters, Rt. 1, W. Va.</u>		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE <u>H. K. Brown</u>		ADDRESS <u>Brown Funeral Home - Martinsburg, W. Va.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 4 1967</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

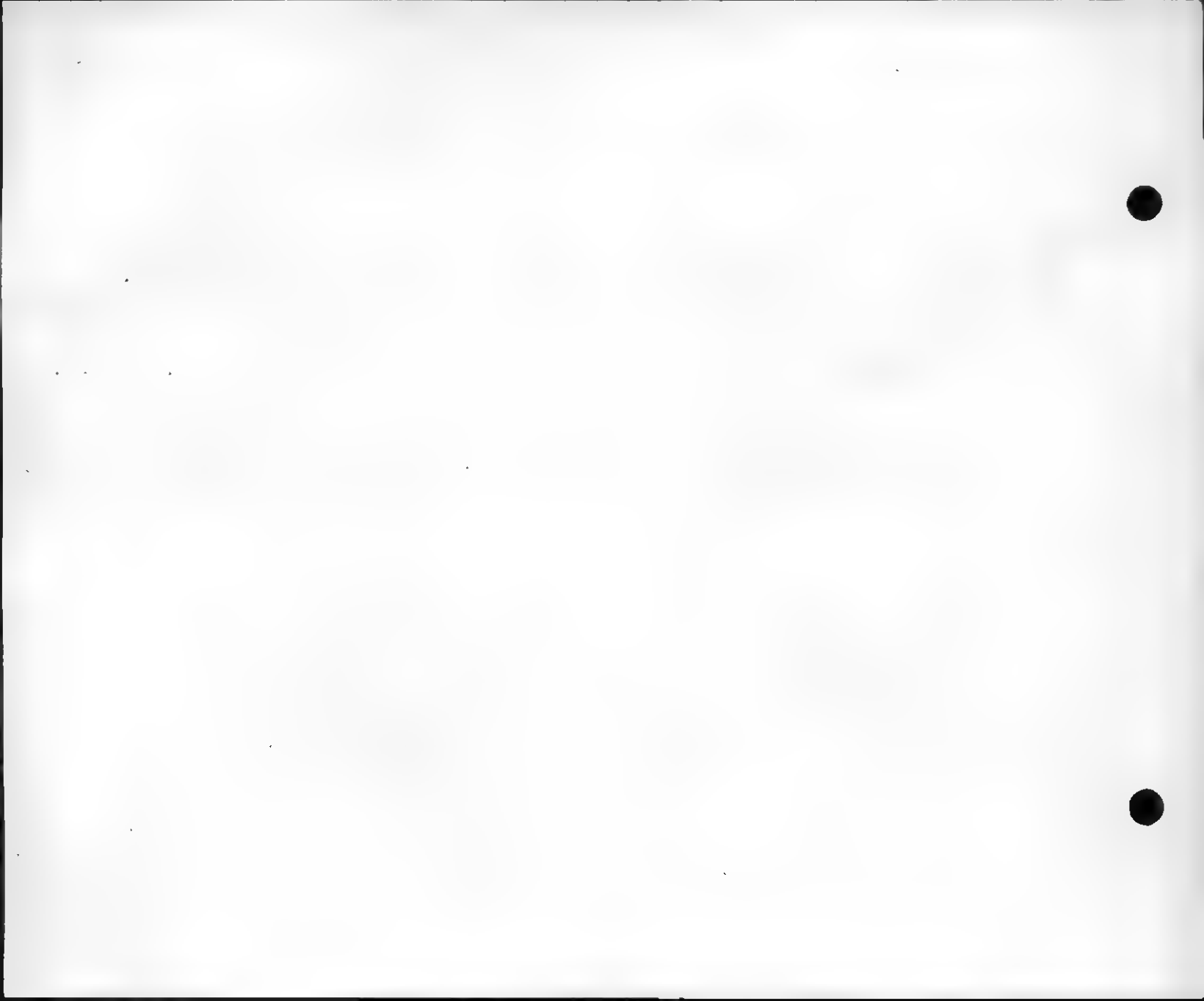
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN		c. LENGTH OF STAY IN IT 6 YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2041 DOWNSVILLE PIKE		d. STREET ADDRESS 2041 DOWNSVILLE PIKE	
3. NAME OF DECEASED (Type or print) First FREDERICK Middle CHARLES Last CARMAN		4. DATE OF DEATH Month NOVEMBER Day 9 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 13, 1904
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 63 Days 63 Hours 63 Min 63	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) SUPERVISOR		10b. KIND OF BUSINESS OR INDUSTRY MACK TRUCKS INC. MIDDLETOWN, NEW YORK.	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM CARMAN		14. MOTHER'S MAIDEN NAME STELLA STEARNS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. 140-05-8273	
17. INFORMANT MRS. FLORENCE E. CARMAN, HAGERSTOWN, MD.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of urinary 1810 DUE TO (b) Bladder Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 18102.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) this hospital attended the deceased from Dec 30 , 1966 to NOV 9 , 1967, that (1) my saw the deceased alive on NOV 7 , 1967, and that death occurred at 5:30 M, from causes and on the date stated above.			
22a. SIGNATURE Edward W. Ditto, III		22b. DATE SIGNED NOV. 9, 1967	
22c. PHYSICIAN'S NAME (Type) EDWARD W. DITTO, III, M.D.		22d. ADDRESS 217 W. WASHINGTON ST. HAGERSTOWN MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 11/9/67	
23c. NAME OF CEMETERY OR CREMATORY GEO. WASHINGTON MEM. CEM. PARAMUS, NEW JERSEY		23d. LOCATION (City or Town) (County) (State) PARAMUS, NEW JERSEY	
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MD.		25. FILED BY REGISTRAR NOV 15 1967	

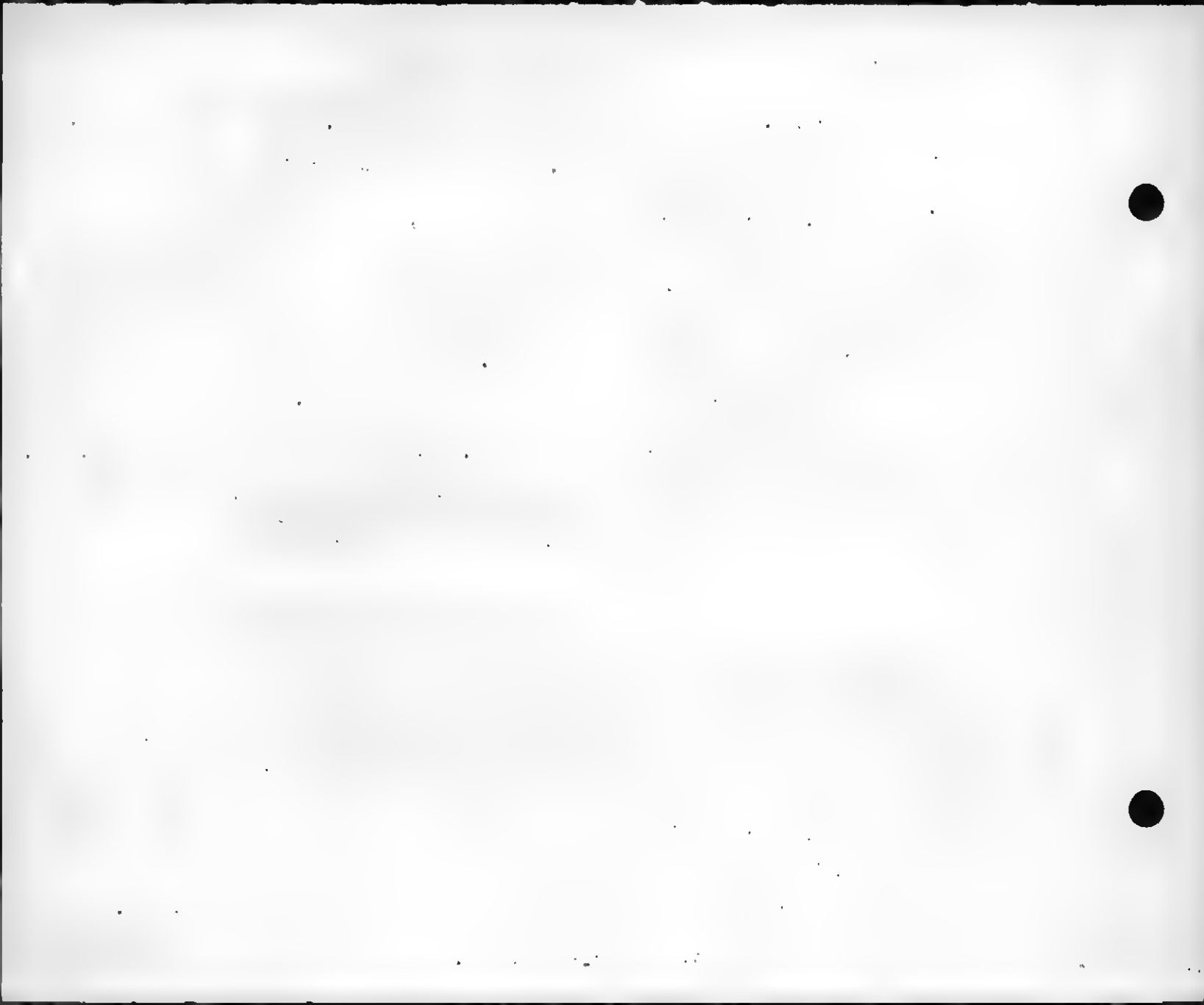


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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Wash. b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 40 Yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 9, Fourth Street					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 9, Fourth Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) John Lee Carter			4. DATE OF DEATH Month November Day 6 Year 19 67						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 16, 05		9. AGE (In years last birthday) 61 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner			10b. KIND OF BUSINESS OR INDUSTRY Auto Repair Gar.			11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Edward Carter					14. MOTHER'S MAIDEN NAME Ida V. Mills				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 217-10-2799		17. INFORMANT Mrs. Kathryn Carter Hagerstown, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Not known Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH 2 Hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 6/19, 1967 to 9/22, 1967 , that (I) (we) last saw the deceased alive on 9/22, 1967 , and that death occurred at 8 PM , from the causes and on the date stated above.									
22a. SIGNATURE Arthur Riego					22b. DATE SIGNED 11-7-67				
22c. PHYSICIAN'S NAME (Type) ARTHUR RIEGO					22d. ADDRESS 119 E. Antietam St.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 11-9-67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Md.		
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.					25a. REC'D BY REGISTRAR NOV 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		



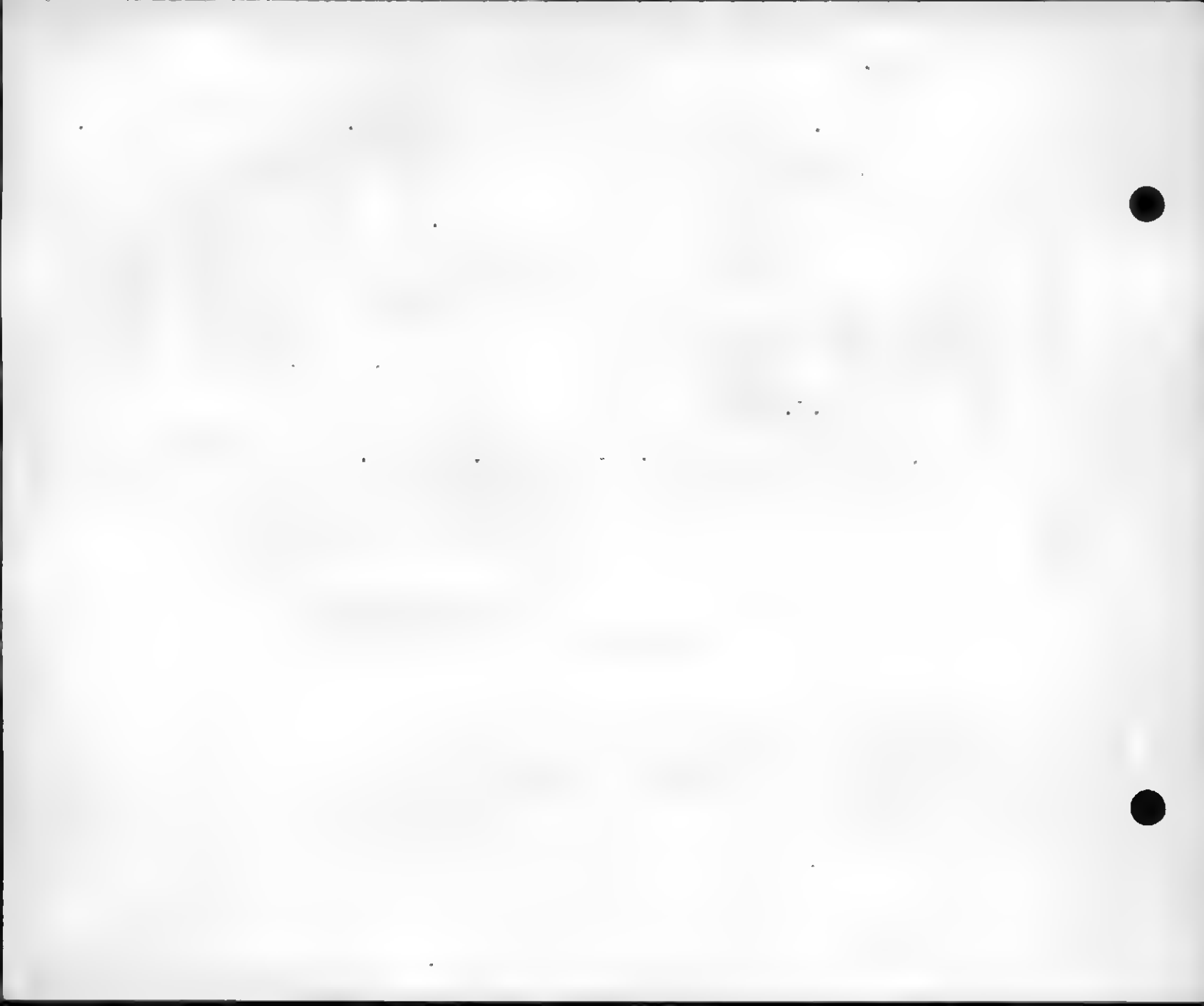
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10086

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Wash. MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution or residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY in 1b 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS Rt. 3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Lawrence John Casey				4. DATE OF DEATH Month Day Year November 27 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-26-1892		9. AGE (In years last birthday) 75 yrs	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (County & State or foreign country) Weston, West, Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME M.J. Casey				14. MOTHER'S MAIDEN NAME Mary Collins			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO 234-18-1582		17. INFORMANT Mrs. Mary S. Casey Hagerstown Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Atherosclerosis DUE TO arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Unknown DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) No history of hypertension						INTERVAL BETWEEN ONSET AND DEATH 8 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 3-31-67 , 19 67 , to 11-27-67 , 19 67 , that (I) (we) last saw the deceased alive on 11-27-67 , 19 67 , and that death occurred at 6:57 PM , from causes and on the date stated above.							
22a. SIGNATURE <i>E. B. Lardizabal</i>				22b. DATE SIGNED 11-28-67		22c. PHYSICIAN'S NAME (Type) E. B. Lardizabal, M. D.	
22d. ADDRESS 300 North Potomac Street Hagerstown, Md.		22e. MED. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-30-67	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Md.			
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR NOV 30 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

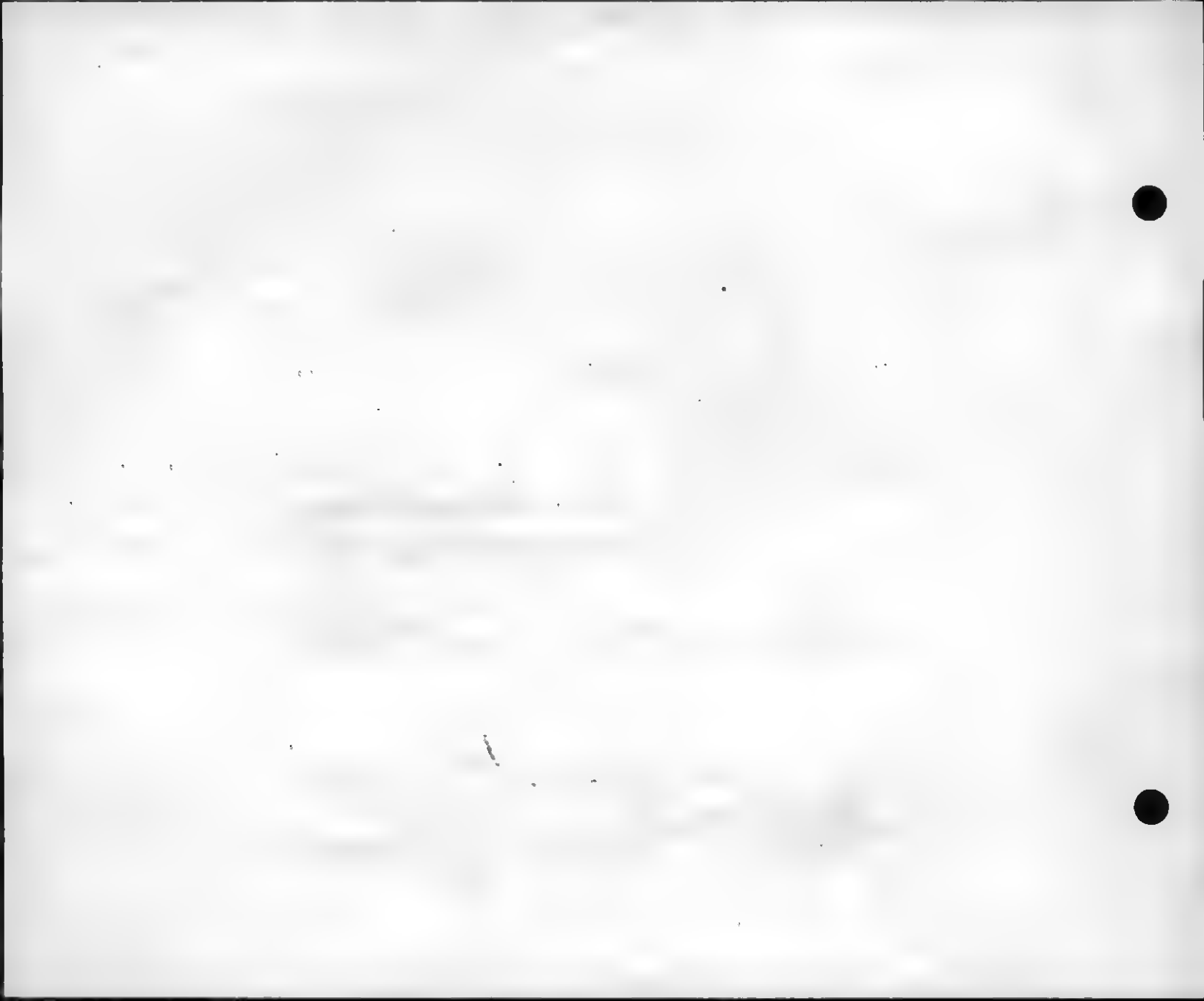
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1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pagerstown</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		d. STREET ADDRESS <u>118 E. Salisbury St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ADOLPHUS</u> Middle <u>WILLIAM</u> Last <u>CHRISMAN</u>		4. DATE OF DEATH Month <u>November</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 24, 1878</u>
9. AGE (In years last birthday) <u>88 yrs</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	11. IF UNDER 24 HRS Hours <u>0</u> Min <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer - foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tannery</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Luther Chrisman</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Rowe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>0</u>		16. SOCIAL SECURITY NO <u>215-0142055</u>	
17. INFORMANT <u>Mr. Eugene Snyder Williamsport, Md.</u>		18. E. Salisbury Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO (b) <u>Arteriosclerosis, Gen.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Just Known</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid Arthritis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 7, 1967</u> to <u>Nov. 8, 1967</u> that (I) (we) last saw the deceased alive on <u>Nov. 8, 1967</u> , and that death occurred at <u>4:25 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Arturo Riego</u>		22b. DATE SIGNED <u>11/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ARTURO RIEGO</u>		22d. ADDRESS <u>119 E. Antietam St.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 11, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Near Clearspring, Maryland</u>
24. FUNERAL DIRECTOR <u>Albert T. Leaf Williamsport, Maryland.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 10 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sharpsburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>RFD #1</u>	
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Melvin</u> Last <u>Churchey</u>		4. DATE OF DEATH <u>Nov. 6-1967</u> Month <u>Nov.</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 27, 1906</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>7</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Sharpsburg Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Washington Churchey</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Frances Lewis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>1.0</u>		16. SOCIAL SECURITY NO. <u>214-36-0457</u>	
17. INFORMANT <u>Mr. Eugene Churchey</u>		Address <u>Sharpsburg Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>4301</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>HYPERTENSION</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/25</u> , 1967, to <u>11/3</u> , 1967, that (I) (we) last saw the deceased alive on <u>11/3</u> 1967, and that death occurred at <u>9 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>R. Amarillo</u>		22b. DATE SIGNED <u>11/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. AMARILLO</u>		22d. ADDRESS <u>Sharpsburg, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 6-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Sharpsburg Wash. Co. Md..</u>
24. FUNERAL DIRECTOR <u>Albert L. Leaf Williamsport Maryland</u>		25a. REC'D BY REGISTRAR <u>NOV 9 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

VR A15 (4)
25M 1/67



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

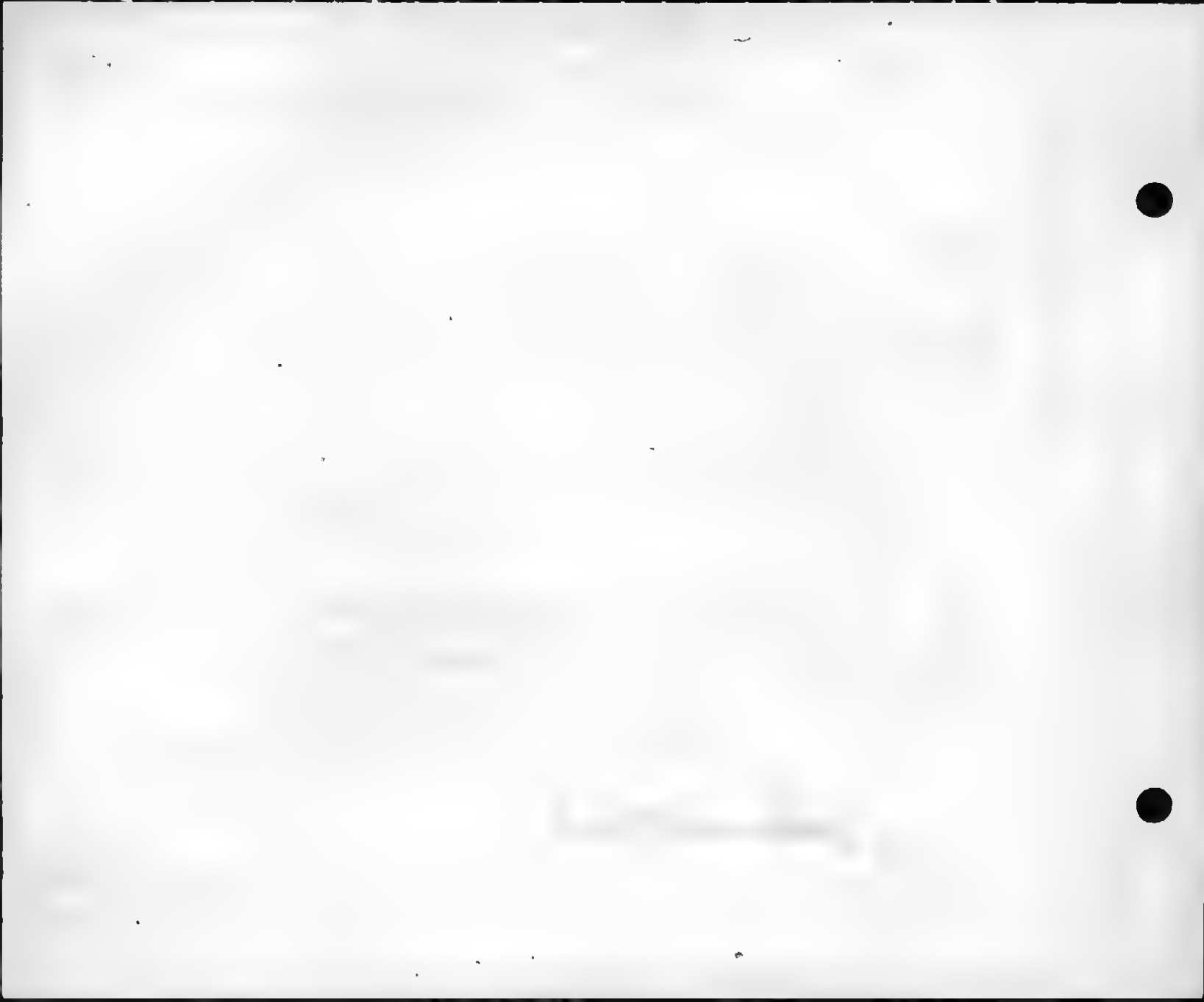
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1967

CERTIFICATE OF DEATH

1967

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>3 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mercersburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Co. Hospital</u>				d. STREET ADDRESS <u>27 W. California St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Henry Clark</u>				4. DATE OF DEATH Month Day Year <u>Nov. 4, 1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/24/1895</u>	9. AGE (In years last birthday) <u>72</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Barbering</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Clearspring, Md., R. 1</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Oliver Clark</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Blair</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>189-18-5037</u>		17. INFORMANT Address <u>Penna.</u> <u>Mrs. William H. Clark, Mercersburg,</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO <u>and malnutrition due to intestinal obstruction due to duodenal ulcer</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>obstruction due to duodenal ulcer</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 1967, to <u>November 19</u> , 1967, that (I) (we) last saw the deceased alive on <u>Nov. 3</u> , 1967, and that death occurred at <u>4A</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Howard N. Weeks</u>				22b. DATE SIGNED <u>11/6/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Howard N. Weeks, M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/7/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Welsh Run Brethren</u>		23d. LOCATION (City or Town) (County) (State) <u>Mercersburg, Pa., R. #2</u>	
24. FUNERAL DIRECTOR <u>T.M. Luning</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18049

18040

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Washington</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Washington</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c LENGTH OF STAY in 1b <u>Lifetime</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>22 W. Potomac Street</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Eve</u> Last <u>Corby</u>		4 DATE OF DEATH Month <u>Nov.</u> Day <u>8</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>April 5 1880</u>
9 AGE (In years last birthday) <u>87</u> yrs		10 IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Williamsport Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>David H. Marsh</u>		14 MOTHER'S MAIDEN NAME <u>Malinda Wilson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>217-56-0373</u>	
17 INFORMANT <u>22 W. Potomac St.</u> <u>Louise Corby Williamsport Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>7330</u> DUE TO (b) <u>Atherosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>disease</u>		INTERVAL BETWEEN DEATH AND DEATH <u>15 yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma uterus? with occlusion of left femoral vessels</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c TIME OF INJURY Month, Day, Year Hour <u>0</u> m <u>0</u> p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-8</u> , 19 <u>67</u> , to <u>9:40 AM</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-8</u> , 19 <u>67</u> , and that death occurred at <u>9:40 AM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>M.E. Byrkit M.D.</u>		22b DATE SIGNED <u>11-9-67</u>	
22c PHYSICIAN'S NAME (Type) <u>M.E. Byrkit M.D.</u>		22d ADDRESS <u>28 West Potomac Street</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b DATE THEREOF <u>Nov. 11-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Williamsport Wash.</u>
24 FUNERAL DIRECTOR <u>Albert L. Teal Williamsport Md.</u>		25a REC'D BY REGISTRAR <u>NOV 13 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form "M-100". Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/87

Items 18&21 Film 395 MARYLAND STATE DEPARTMENT OF HEALTH
12-13-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

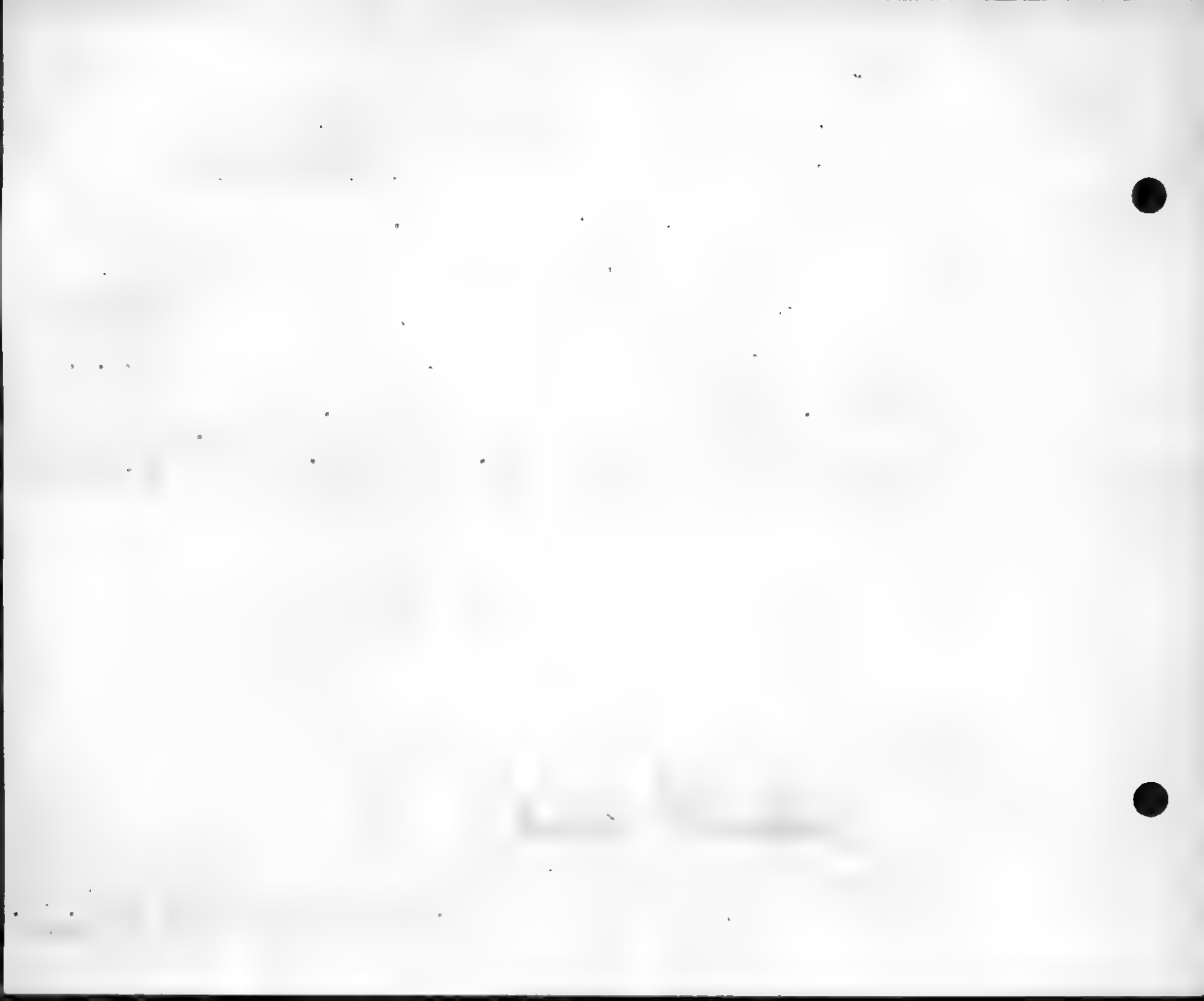
10049

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10041

1 PLACE OF DEATH a COUNTY WASHINGTON MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE MARYLAND b. COUNTY WASHINGTON	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c LENGTH OF STAY In 1b LIFE	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e STREET ADDRESS RT.#1	
3 NAME OF DECEASED (Type or print) First Middle Last TAMMY LYNN COSENS		4 DATE OF DEATH Month Day Year NOVEMBER 28 19 67	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2/21/1965
9 AGE (in years last birthday) 2 yrs		10 FINDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		12 KIND OF BUSINESS OR INDUSTRY MARYLAND	
13 BIRTHPLACE (State or foreign country) MARYLAND		14 CITIZEN OF WHAT COUNTRY? U.S.A.	
15 FATHER'S NAME THEODORE C. COSENS		16 MOTHER'S MAIDEN NAME MILDRED P. SMITH	
17 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		18 SOC. A. SECURITY NO. NONE	
19 INFORMANT MR. THEODORE C. COSENS		20 RT.#1 HAGERSTOWN MD.	
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pending Final Autopsy/protocol 490x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Aspiration of gastric fluid DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Lobular pneu. bilat.			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
21a TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	21b INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21c PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	21d (City or town) (County) (State)
21 I certify that I took charge of the remains described above held on Autopsy <input checked="" type="checkbox"/> . Inspect on <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Howard N. Weeks, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 580 Northern Ave. Address (Street, city, town or county) Hagerstown, Md.	
22a B. RIAL CREMATION REMOVED	22b DATE THEREOF 12/1/67	22c NAME OF CEMETERY OR CREMATORY CEDAR LAWN MEM. GARDENS HAGERSTOWN WASH. MD.	22d LOCATION (City or Town) (County) (State)
23 FUNERAL DIRECTOR W. J. Hornum, Hagerstown, Md.		24 REC'D BY REG STRAR DATE DEC 4 1967	

11/29/67
22. DATE SIGNED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10050

10042

1. PLACE OF DEATH a COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY WASHINGTON			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN It 75 YRS.		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) AVALON MANOR NURSING HOME				d STREET ADDRESS RT.#4		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANGLE Middle MARTIN Last DALEY SR.				4. DATE OF DEATH Month NOVEMBER Day 3 Year 19 67			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/4/1878	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FLAGMAN		10b. KIND OF BUSINESS OR INDUSTRY RAIL ROAD		11. BIRTHPLACE (County & State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS DALEY				14. MOTHER'S MAIDEN NAME SUSAN COSEY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 717-07-9249		17. INFORMANT MRS. CATHERINE MICKEY HAGERSTOWN			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH Sept 6 indef	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour, a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat White <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-6 , 19 67 , to death , 19 67 , that (I) (we) last saw the deceased alive on 9-4-67 , 19 67 , and that death occurred at 4pm , from causes and on the date stated above							
22a. SIGNATURE F. E. ROSKLO / Robert F. Koad				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 11-4-67	
22c. PHYSICIAN'S NAME (Type) F. E. ROSKLO				22d. ADDRESS Hagerstown Md.			
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE THEREOF 11/6/67		23c. NAME OF CEMETERY OR CREMATORY PLEASANT HILL U.B. CHURCH COSEYTOWN PENNA.		23d. LOCATION (City or town) (County) (State)	
24. FUNERAL DIRECTOR W. T. Norment, Hagerstown, Md.				25a. REC'D BY REGISTRAR NOV 8 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



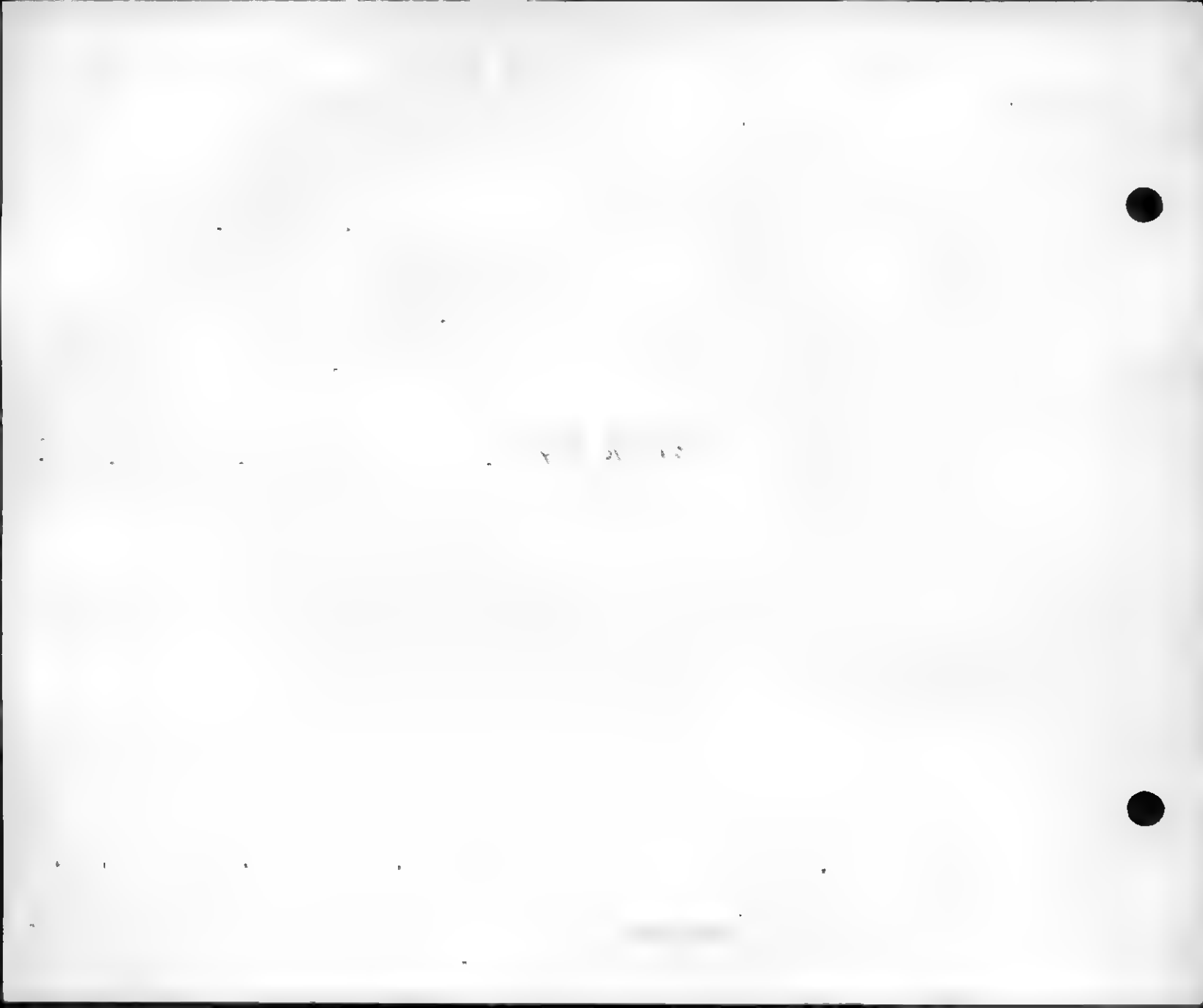
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>200 S. Artizan St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mattie</u> Middle <u>Belle</u> Last <u>Dawson</u>		4. DATE OF DEATH Month <u>November</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 6, 1885</u>
9. AGE (in years last birthday) <u>82</u> yrs		10. UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	11. BIRTHPLACE (County & State, or foreign country) <u>Page County, Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Franklin Jewell</u>	
14. MOTHER'S MAIDEN NAME <u>Anna Printz</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>216-46-879</u>		17. INFORMANT <u>Mrs. Maurice Miller 200 S. Artizan St. Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>splinter myocardial infarction</u> DUE TO <u>coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>one year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>coronary atherosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-6</u> , 19 <u>67</u> , to <u>11-17-1</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-17-</u> 19 <u>67</u> , and that death occurred at <u>8:30 AM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>John C. Stauffer</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Dr. John Stauffer</u>		22d. ADDRESS <u>145 S. Prospect St. Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/19/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Hagerstown Washington Md.</u>	
24. FUNERAL DIRECTOR <u>Rest Haven Funeral Chapel</u>		25a. REC'D BY REGISTRAR <u>John A. Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>NOV 22 1967</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
20 M 1/67

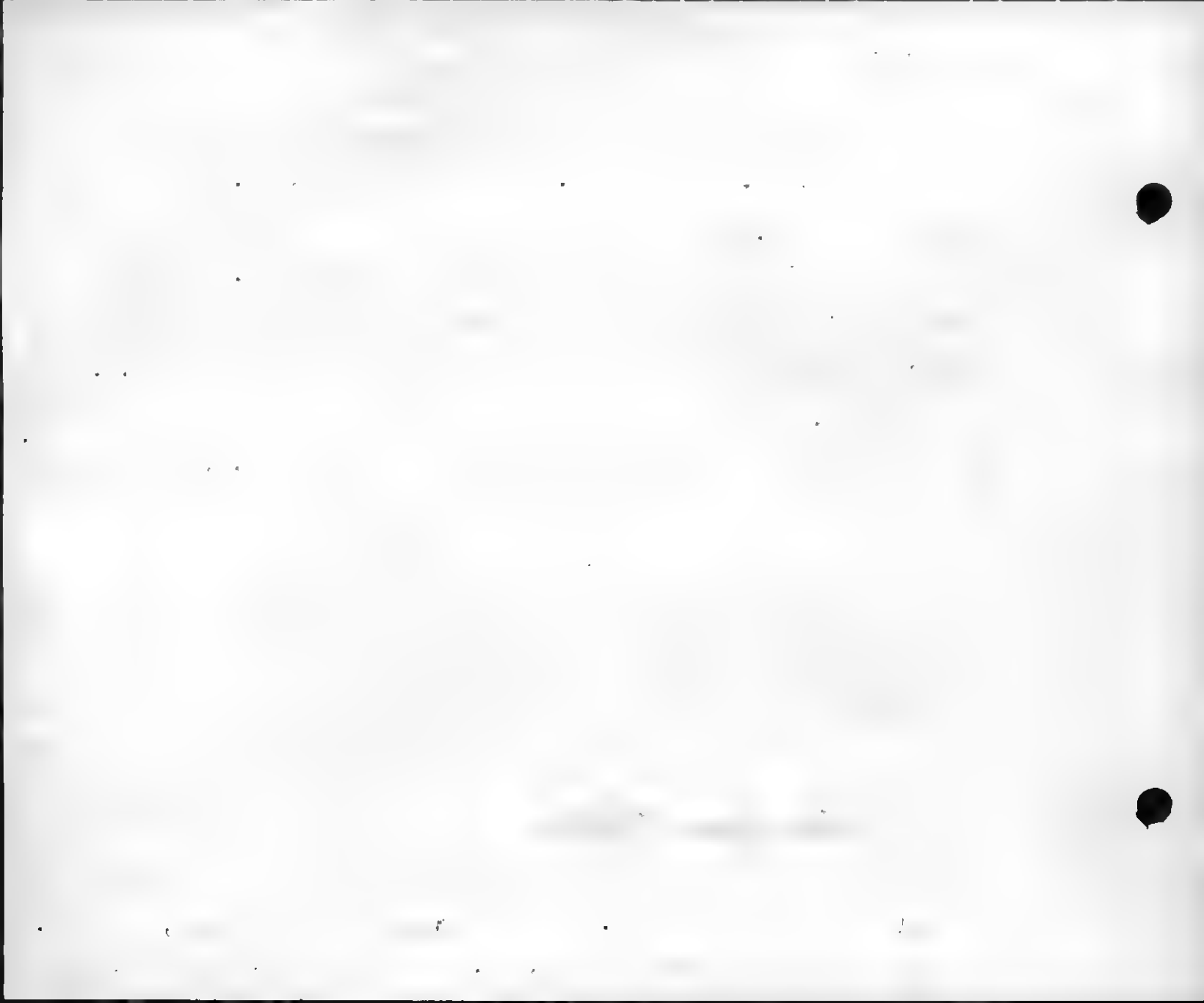
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16052

13944

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.				c. LENGTH OF STAY IN 1b 24 hrs.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clear Spring, Md.				d. STREET ADDRESS Rural 1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Co. Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Charles Edward Dennis				4. DATE OF DEATH Month Day Year Nov. 25 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 5/25/93		9. AGE (In years last birthday) 74 yrs	IF UNDER 1 YEAR Months Days Hours Min. 6 0 0 0	
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Maintenance Fairchild		10b. KIND OF BUSINESS OR INDUSTRY Washington		11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Tobias H. Dennis				14. MOTHER'S MAIDEN NAME Elmira Cunningham			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. 217-09-9833		17. INFORMANT Address Md. Mrs Hazel Dennis Rd.1, Clear Spring			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory acidosis DUE TO Chronic obstructive lung disease with pulmonary Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ?? DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Hypertension Cor Pulmonale							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Oct. 12 , 19 67 , to Nov. 25 , 19 67 , that (I) (we) lost the deceased alive on Nov. 25 , 19 67 and that death occurred at 4:45 PM , from causes and on the date stated above.							
22a. SIGNATURE Archie Robert Cohen, M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/27/67	
22c. PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.				22d. ADDRESS Clear Spring, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/28/67		23c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery		23d. LOCATION (City or Town) (County) (State) Clear Spring Md.	
24. FUNERAL DIRECTOR Margaret Rowland, Clear Spring, Md.				25. REC'D BY REGISTRAR NOV 29 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

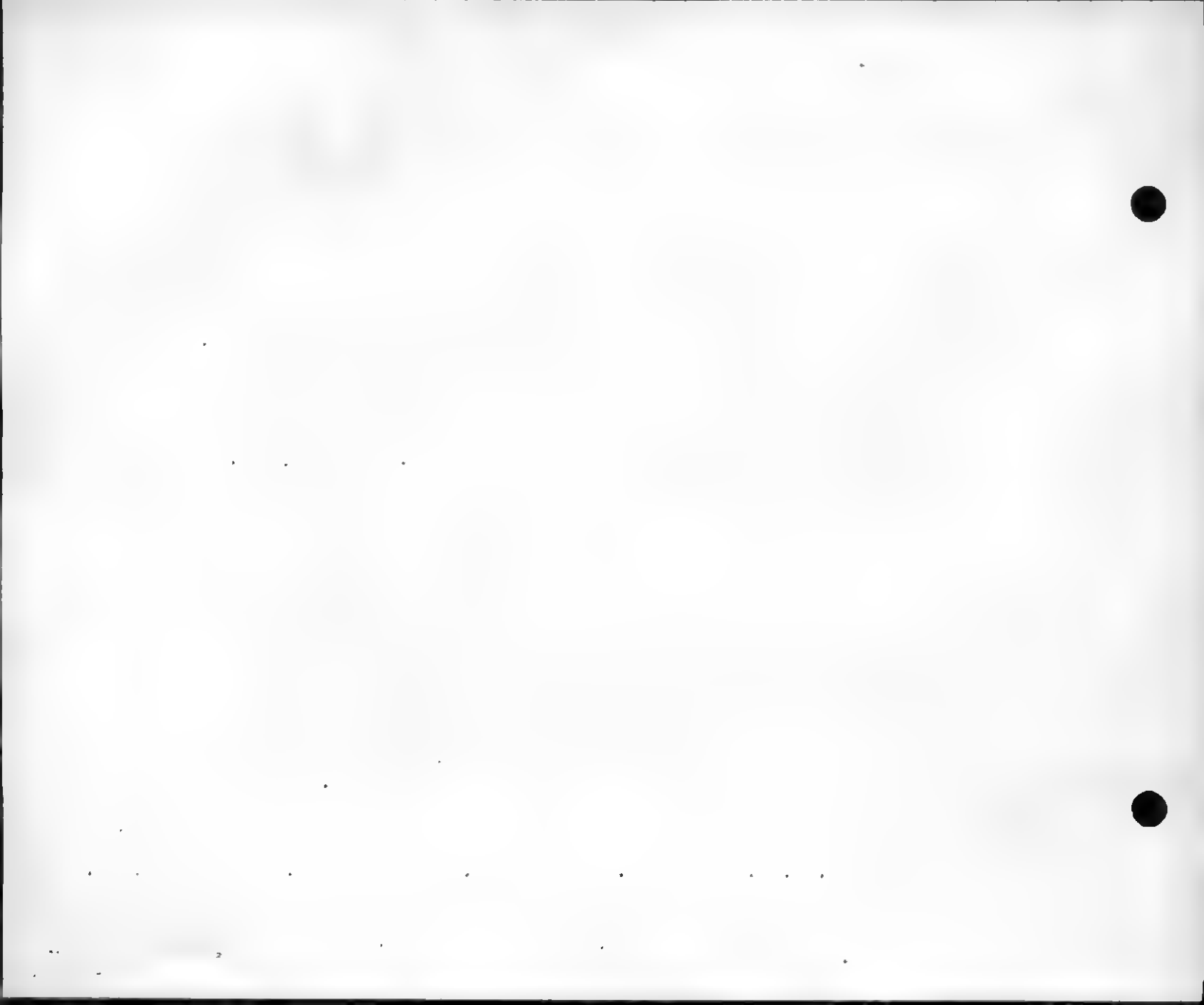
CERTIFICATE OF DEATH

16045

1 PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 1 Day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 13 West Baltimore St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last RUTH ELLA DIGGS		4 DATE OF DEATH Month Day Year Nov 28 1967 19	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 3 1894
9. AGE (in years last birthday) 73 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (County & State, or foreign country) Md. Union Bridge Carroll Co		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph A Haines		14. MOTHER'S MAIDEN NAME Susan Frock	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-09-4709	
17. INFORMANT George F. Digg		Address 13 W. Baltimore St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerotic Vascular Disease DUE TO (c) ---		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hours Several years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11-27- , 19 67 , to 11-28- , 19 67 , that (I) (we) last saw the deceased alive on 11-28- , 19 67 , and that death occurred at 8 A. M, from causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED 11-29-67	
22c. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.		22d. ADDRESS 215 W. Washington St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/30/67	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md
24. FUNERAL DIRECTOR Andrew K. Coffman		25a. REC'D BY REGISTRAR DEC 1 1967	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



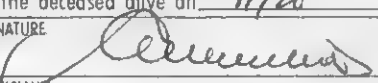

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

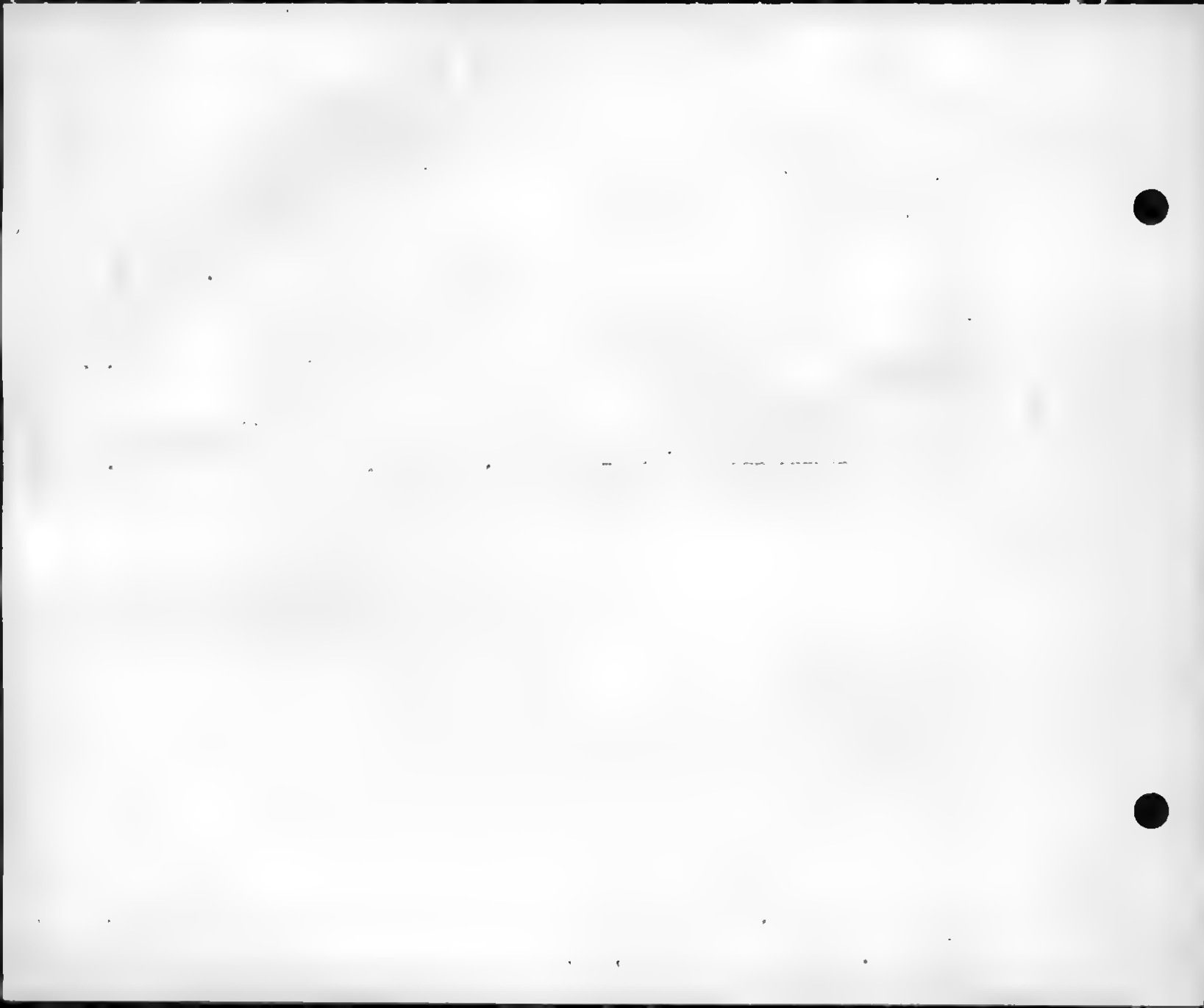
CERTIFICATE OF DEATH

16046

10054

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

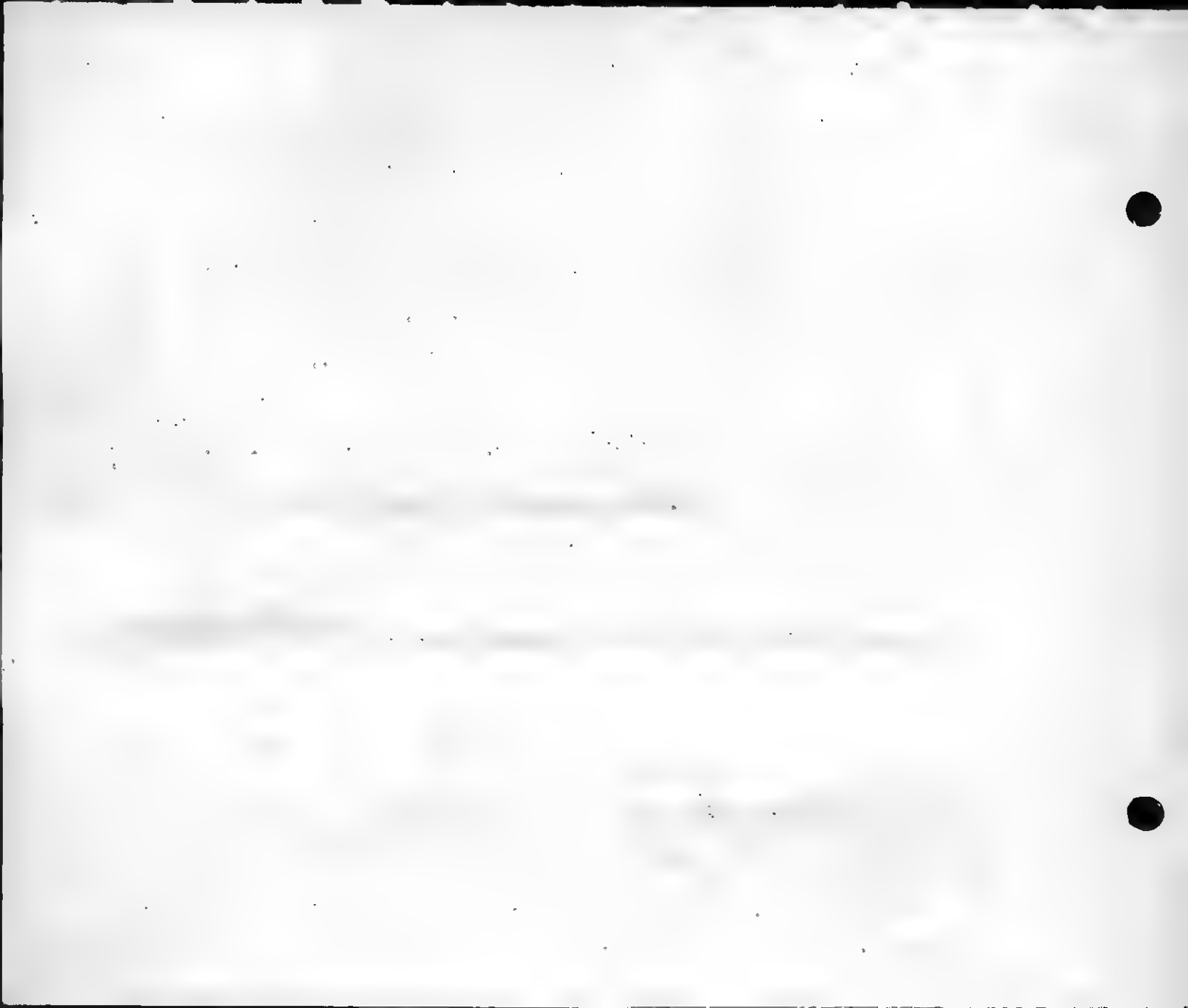
1 PLACE OF DEATH a. COUNTY Washington MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sharpsburg				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Antietam Harpers Ferry RFD #1				d. STREET ADDRESS Antietam Harpers Ferry RFD 1			
3 NAME OF DECEASED (Type or print) First Mary Middle Ethel Last Ebersole				4. DATE OF DEATH Month Nov. Day 26 Year 19 67			
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 23 1908	9 AGE (In years last birthday) 59 yrs	IF UNDER 1 YEAR Months 5 Days 2	IF UNDER 24 HRS hours 2 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Home		11 BIRTHPLACE (County & State, or foreign country) Maryland		
12 CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles Metz				14. MOTHER'S MAIDEN NAME Ellen Jamison			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-20-1354		17. INFORMANT Mr. Dennis M. Ebersole Harpers Ferry RFD Dargan Md. #1			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH SUDDEN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/31 , 19 66 , to 11/20 , 19 67 , that (I) (we) last saw the deceased alive on 11/20 , 19 67 , and that death occurred at 8 A.M. from causes and on the date stated above.							
22a. SIGNATURE 				22b. DATE SIGNED 11/27/67			
22c. PHYSICIAN'S NAME (Type) R. Amarillo				22d. ADDRESS 120 W. Main St SHARPSBURG MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 28-67		23c. NAME OF CEMETERY OR CREMATORY Samples Manor Cemetery		23d. LOCATION (City or Town) (County) (State) Samples Manor Wash. Md.	
24. FUNERAL DIRECTOR Albert L. Leaf Williamsport, Md.				25a. REC'D BY REGISTRAR DATE NOV 30 1967		25b. REGISTRAR'S SIGNATURE 	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10055
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10047
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b one week		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 139 Summit Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Carrie Elizabeth Eckstine				4. DATE OF DEATH Month Day Year Nov. 2 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 24, 1886		9. AGE (In years last birthday) 31 yrs	10. UNDER 1 YEAR Months 2 Days 5	11. UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Washington Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Isaiah Eckstine				14. MOTHER'S MAIDEN NAME Cecelia Ann Summers			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 0		16. SOCIAL SECURITY NO. 204-10-6258		17. INFORMANT 104 Williams Circle Dr. Kenneth Eckstine Sr. Williamsport, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Tubercular pneumonia, right lower lobe</i> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Concurrent Spherocytic anemia & splenectomized spleen. Rheumatic Heart Disease & aortic & mitral valves.</i>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>None</i>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 1962, to Nov. 2, 1967, that (I) (we) last saw the deceased alive on Nov. 2, 1967, and that death occurred at 2:00 PM, from the causes and on the date stated above.							
22a. SIGNATURE <i>Edson P. Jedy</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) EDSON P. JEDY				22d. ADDRESS Hagerstown, Maryland.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 5, 1967	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) Hagerstown, Maryland (State)			
24. FUNERAL DIRECTOR Albert L. Leaf		ADDRESS Williamsport, Md.		25a. REC'D BY REGISTRAR NOV 7 1967		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

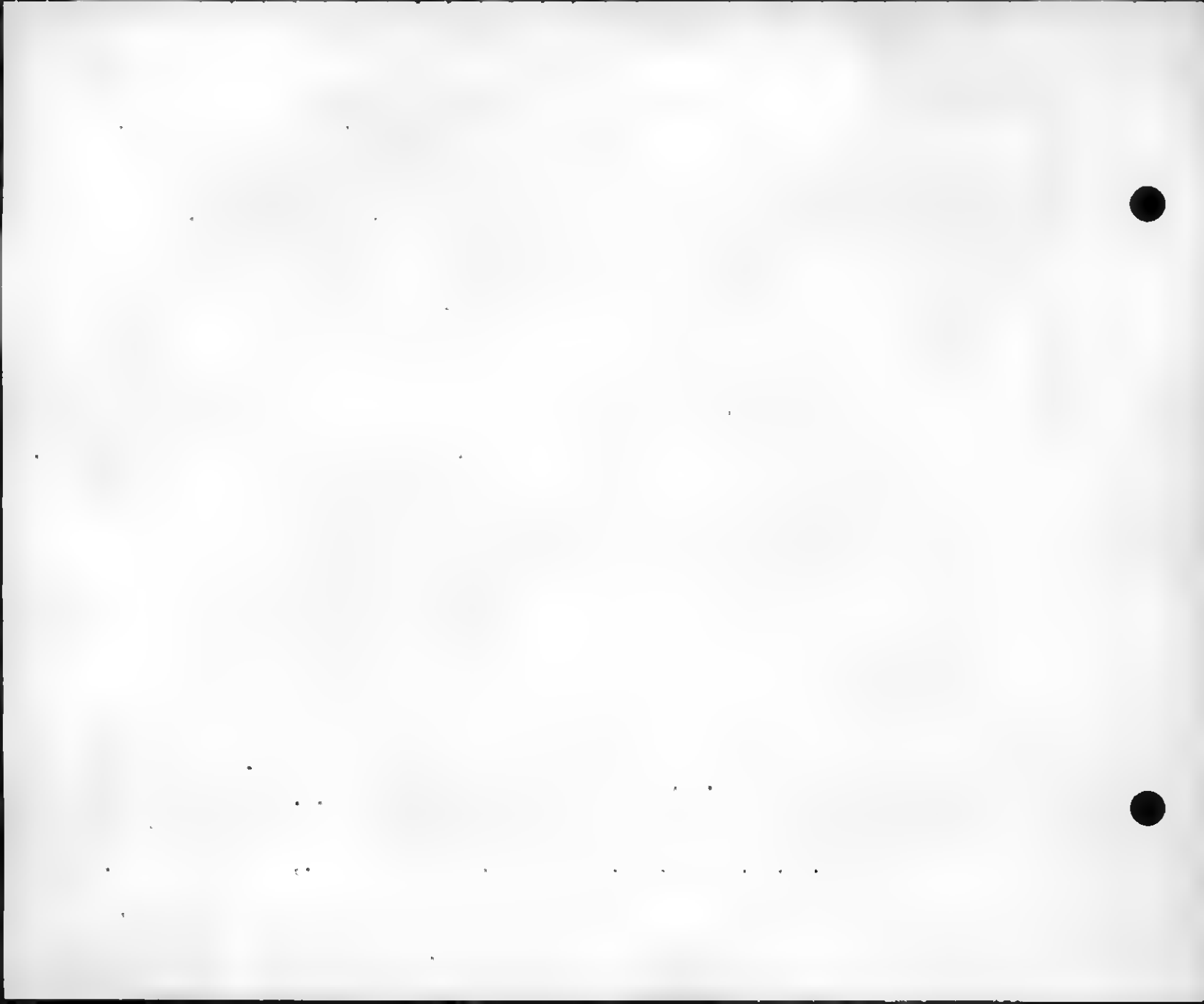
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16053

16048

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Jackson Convalescent Home				d. STREET ADDRESS 269 S. Prospect St.			
3. NAME OF DECEASED (Type or print) First Clara Middle Alice Last Fisher				4. DATE OF DEATH Month November Day 23 Year 1967			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-3-85	9. AGE (In years last birthday) 82 yrs.	10. IF UNDER 1 YEAR Months Days Hrs. Min.		11. IF UNDER 24 HRS. Hrs. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Julius C. Fisher				14. MOTHER'S MAIDEN NAME Johanna Burkhart			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Anna Burns, Silver Spring, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Vascular Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 21, 1967 to Nov. 23, 1967 that (I) (we) last saw the deceased alive on Nov. 3, 1967 , and that death occurred at 12:05M , from causes and on the date stated above							
22a. SIGNATURE <i>E. W. Ditto, Jr.</i>				A.M. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 11-25-67	
22c. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.				22d. ADDRESS 215 W. Washington St., Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-25-67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.				25a. REC'D BY REGISTRAR NOV 27 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

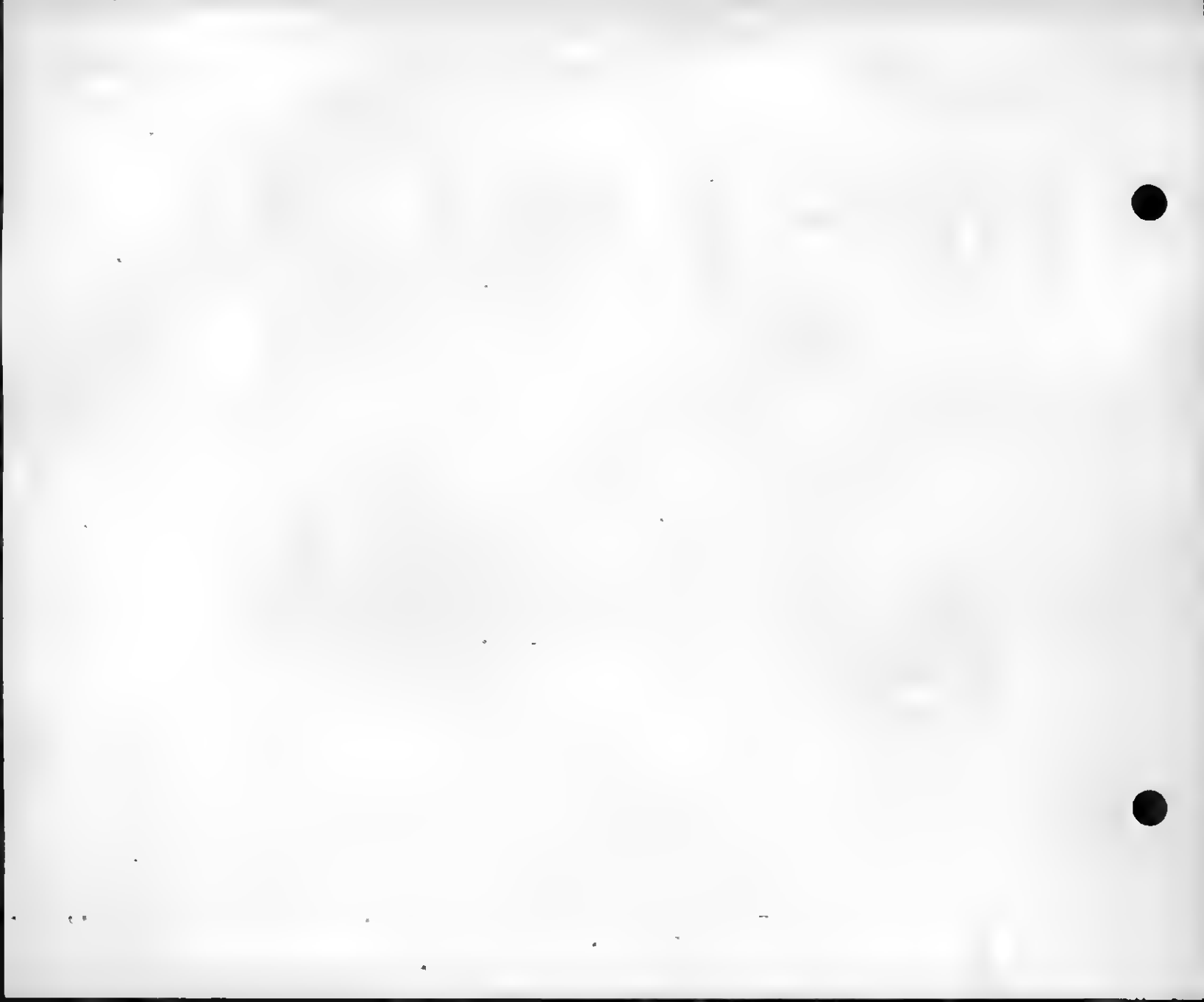
10057

10049

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport, Md.</u>		c. LENGTH OF STAY IN 1b <u>7 to 5 Mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Homewood Church Home Inc</u>				d. STREET ADDRESS <u>105 E Washington</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Leena</u> Middle <u>V.</u> Last <u>FITEZ</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>21</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 31, 1881</u>		9. AGE (In years last birthday) <u>86</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeper</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Emmitsburg</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lewis A. Bollinger</u>				14. MOTHER'S MAIDEN NAME <u>Martha E. Rhoades</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-04-72530</u>		17. INFORMANT <u>Mark G. Wagner, Supt.</u> Address <u>2700 12 Ave Wmport, Ind.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertensive C.V. Dis</u> 475X DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cancer of Colon - 5 years before death</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 15</u> , 19 <u>65</u> , to <u>Nov</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov 16</u> , 19 <u>67</u> , and that death occurred at <u>7:00</u> P.M., from causes and on the date stated above.							
22a. SIGNATURE <u>Robert P. Conrad</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>11-22-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert P. Conrad</u>				22d. ADDRESS <u>137 W. Washington Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-25-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>United Brethren Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Thurmont Fred Co., Md.</u>	
24. FUNERAL DIRECTOR <u>Raymond E. Greager</u>				25a. REC'D BY REGISTRAR <u>Raymond E. Greager</u> ADDRESS <u>Thurmont, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

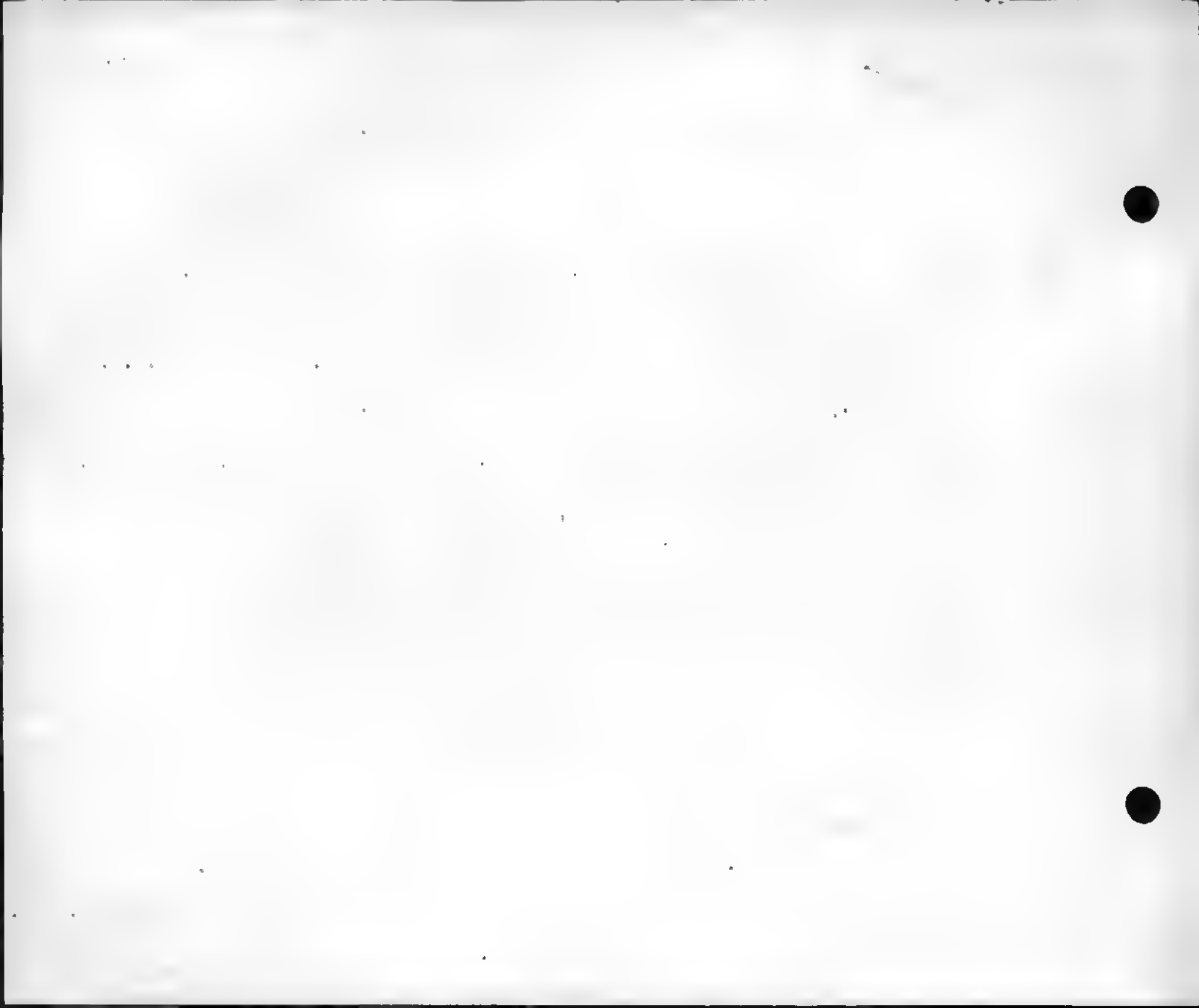
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16050

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Highfield		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle H. Last Fitz		4. DATE OF DEATH Month Nov. Day 10 Year 1967	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1/29/1904
9. AGE (in years last birthday) 63 yrs		10. UNDER 1 YEAR Months 63 Days 0 Hours 0 Min 0	11. UNDER 24 HRS Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Highfield Md.	
11. BIRTHPLACE (County & State, or foreign country) Highfield Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles L. Fitz		14. MOTHER'S MAIDEN NAME Bertha S. Gall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 188-05-6558	
17. INFORMANT Mrs. Catherine Greenawalt, Cascade Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Coronary Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Coronary Atherosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. , 19 60 , to 10 Nov. , 19 67 , that (I) (we) last saw the deceased alive on 9 Nov. 19 67 , and that death occurred at 6:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Robert A. Kiefer		22b. DATE SIGNED 10 Nov 67	
22c. PHYSICIAN'S NAME (Type) Robert A. Kiefer		22d. ADDRESS Blue Ridge Summit Pa.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/12/67	
23c. NAME OF CEMETERY OR CREMATORY Bethel		23d. LOCATION (City or Town) (County) (State) Lantz #1, Frederick Co., Md.	
24. FUNERAL DIRECTOR Walter J. Grove		25a. REC'D BY REGISTRAR Waynesboro Pa.	
25b. REGISTRAR'S SIGNATURE Walter J. Grove		DATE NOV 14 1967	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10059

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10051

1 PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN It		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 2035 Virginia Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Andrew Middle Edward Last Fleming		4 DATE OF DEATH Month November Day 23 Year 67	
5 SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11-18-67
9 AGE (In years last birthday) 23		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (County & State or foreign country) Hagerstown, Md.		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME Joseph Fleming		14 MOTHER'S MAIDEN NAME Joan Forsyth	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Joseph Fleming, Hagerstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO Subarachnoid Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Prematurity (2 lbs 9 oz) (c) Prematurity (2 lbs 9 oz)		INTERVAL BETWEEN ONSET AND DEATH 4 days 4 days 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 11/18/67 , 19 67 , to 11/23/67 , 19 67 , that (I) (we) last saw the deceased alive on 11/24 , 19 67 , and that death occurred at 12:15 AM , from causes and on the date stated above			
22a SIGNATURE A. M. Bacon		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d ADDRESS	
23a B. RIAL CREMATION, REMOVAL (Specify)	23b DATE THEREOF 11-24-67	23c NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d LOCATION (City or Town) (County) (State) Hagerstown, Md.
24 FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a REC'D BY REGISTRAR NOV 27 1967	
25b REGISTRAR'S SIGNATURE Charles J. J...			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 7 Film G39511/21/67 KK

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

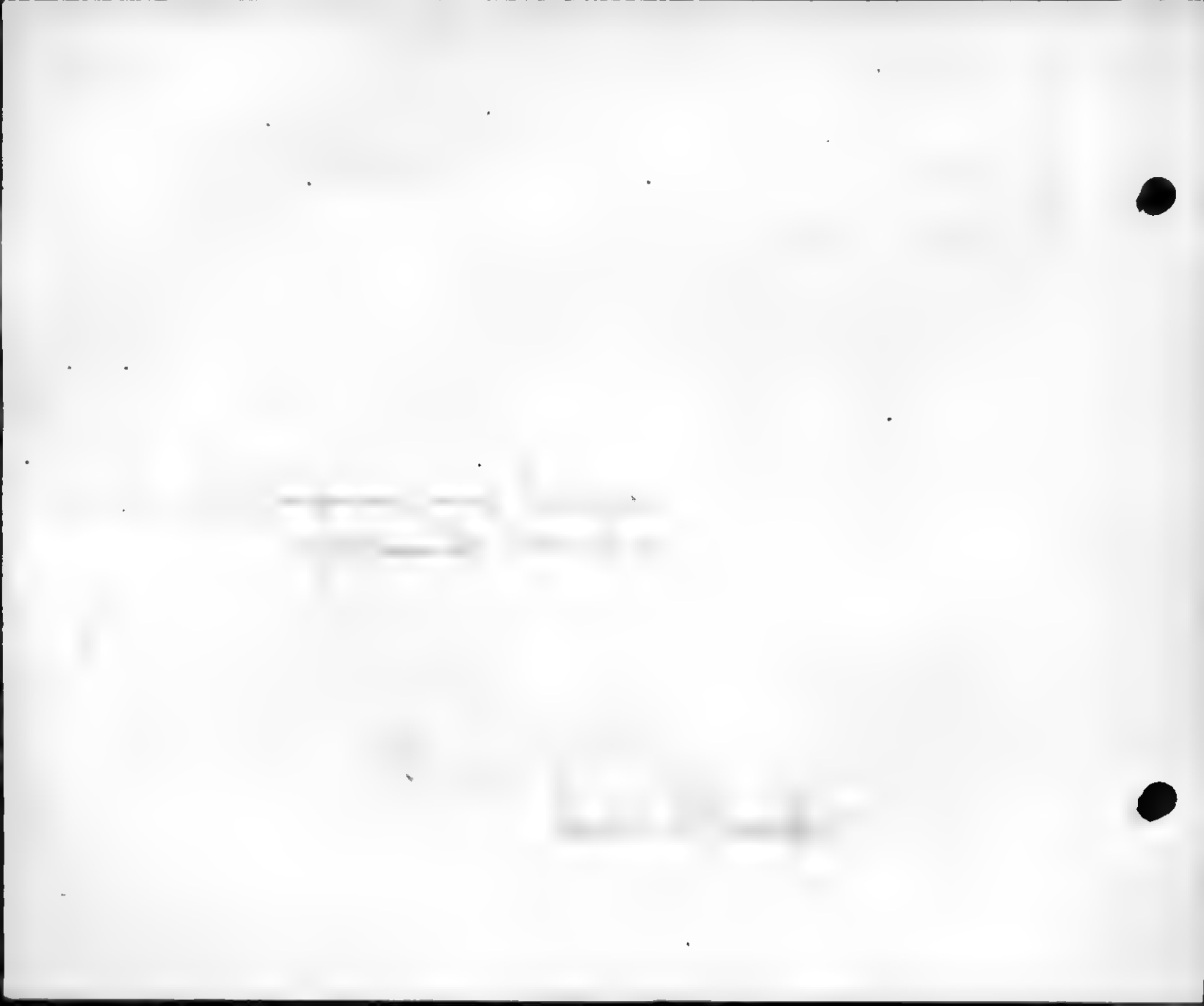
10052

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY WASHINGTON		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD COUNTY WYD PG ✓ 4184 - Woodyard Rd	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ***** / Upper Marlboro, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro ***** / Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS ***** / *****	
3 NAME OF DECEASED (Type or print) First Ronald Middle Forbes Last Forbes		4. DATE OF DEATH Month 11 Day 10 Year 67	
5 SEX Male	6 COLOR OR RACE Colored	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4/18/48
9. AGE (In years, last birthday) 19 yrs		IF UNDER 1 YEAR Months 10 Days 10 Hours 67 M.n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11 BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John T. Forbes		14. MOTHER'S MAIDEN NAME Mary Boone	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. None	
17 INFORMANT Mrs. Mary Forbes		Address Upper Marlboro, Md.	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 330Y IMMEDIATE CAUSE (a) ruptured berry aneurysm intra ventricular hemorrhage DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Howard N. Weeks EXAMINER'S NAME (Type) Howard N. Weeks (Resurrection)		22. DATE SIGNED 11/10/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) 11-19-67		23b. DATE INTERRED 11-19-67	
23c. NAME OF CEMETERY OR CREMATORY *****		23d. LOCATION (City or town) (County) (State) Clinton Md	
24. FUNERAL DIRECTOR Rollins 4339 - Hunt Rd NE		25a. REC'D BY REGISTRAR NOV 16 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

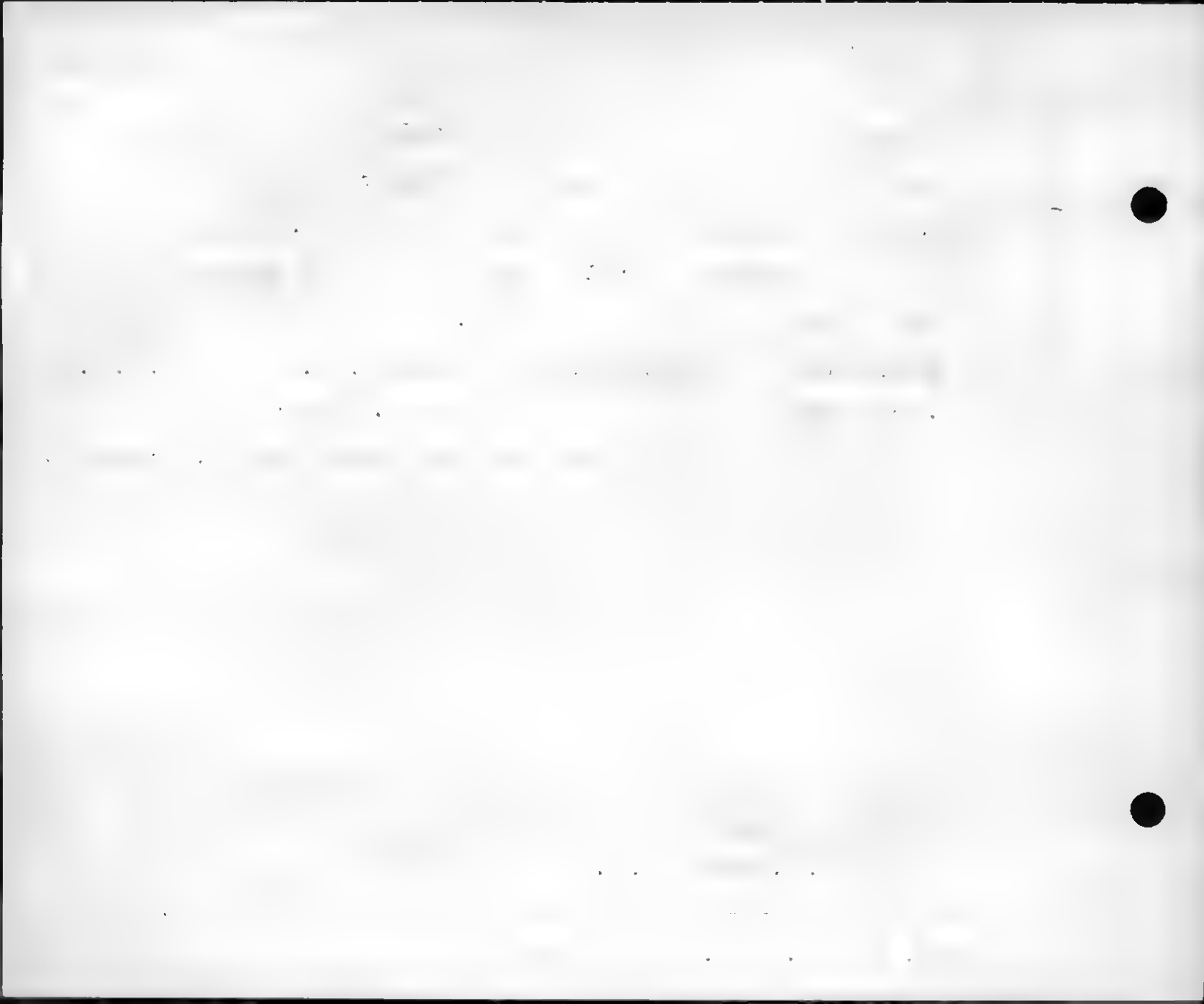
18053

10061

1. PLACE OF DEATH a. COUNTY Washington MIDDLE				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 10 Days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Co unty Hospital				d. STREET ADDRESS 119 Lakin Ave.			
3. NAME OF DECEASED (Type or print) First Middle Last Kathleen Lucille Ford				4. DATE OF DEATH Month Day Year November 29, 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 8, 1903		9. AGE (in years lost birthday) 64 yrs	10. IF UNDER 1 YEAR Months Days Hours Min 0 21	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY County Schools		11. BIRTHPLACE (County & State, or foreign country) Boonsboro, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME J. Berry Gantz				14. MOTHER'S MAIDEN NAME Annie V. Blecker			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 219-36-3585		17. INFORMANT Address Mrs. Glenn Hendrix, Box 114, Glenarm, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Suit Arterial Hemorrhage DUE TO (b) Registered Central Aneurysm DUE TO (c) Bilateral Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/19 , 19 67 , to 11/29 , 19 67 that (I) (we) last saw the deceased alive on 11/29 , 19 67 , and that death occurred at 7:30PM , from causes and on the date stated above.							
22a. SIGNATURE Wm. O. Rexrode				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 12/1/67	
22c. PHYSICIAN'S NAME (Type) Wm. O. Rexrode, M. D.				22d. ADDRESS 1955 Prospect St Hagerstown			
23a. BURIAL, CREMATION, or other disposal (Specify) Burial		23b. DATE THEREOF 12- 2- 67		23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery		23d. LOCATION (City or Town) (County) (State) Boonsboro, Md.	
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.				25a. REC'D BY REGISTRAR DATE DEC 5 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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VR A15 (4)
25M 1/67

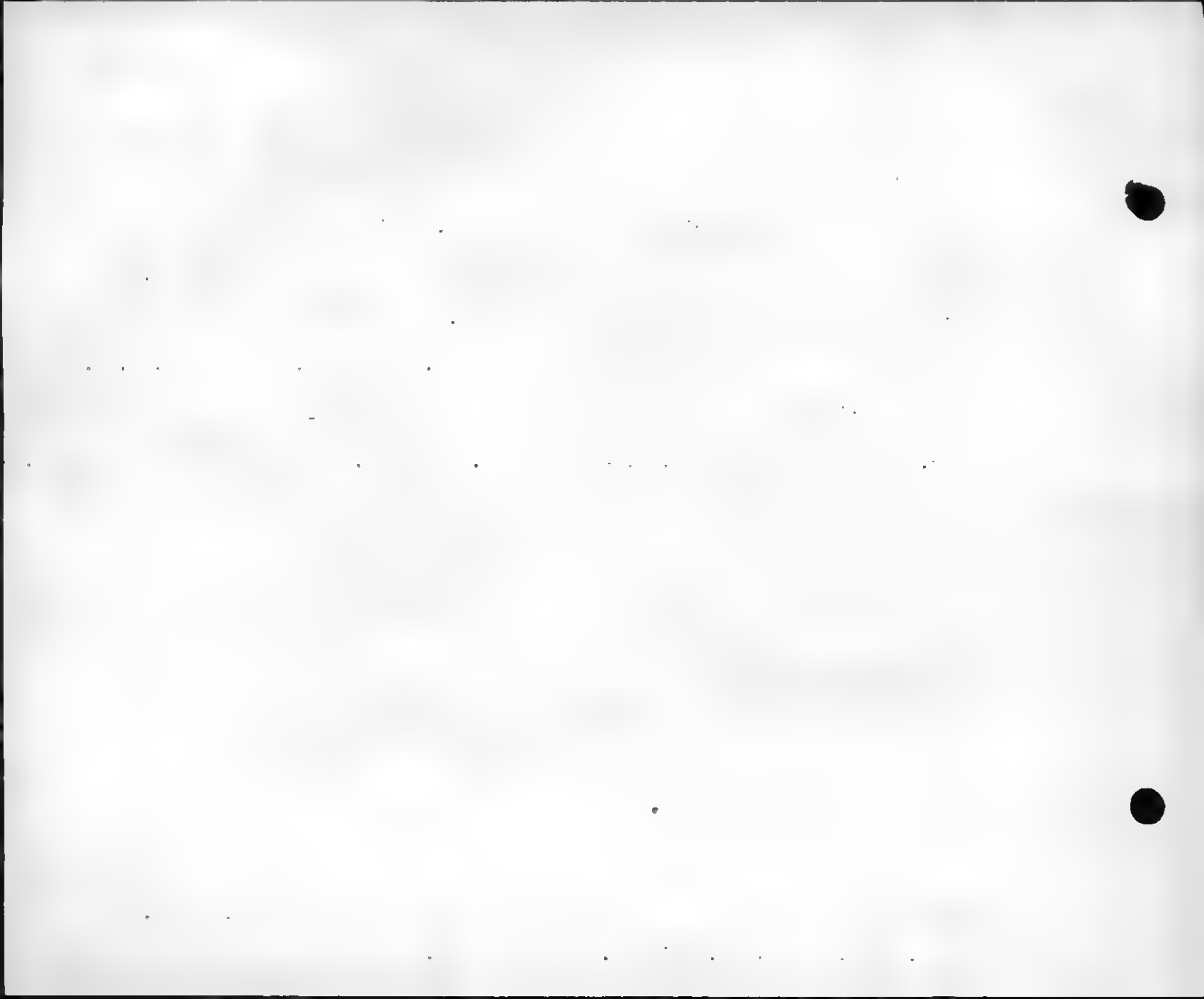
16062

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16054

1 PLACE OF DEATH a. COUNTY Washington MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 1 Day			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Keedysville Rfd. 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS Mt. Brair		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Fred Newton Griffith				4 DATE OF DEATH Month Day Year November 18, 1967			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept. 16, 1892		9 AGE (In years lost birthday) yrs 75	IF UNDER 1 YEAR Months Days Hours Min 2 2	IF UNDER 24 HRS Hours Min 24
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11 BIRTHPLACE (County & State or foreign country) Mt. Brair, Md.		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13 FATHER'S NAME Joseph Griffith				14. MOTHER'S MAIDEN NAME Jeanette Smith			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16 SOCIAL SECURITY NO. 215-14-1864		17. INFORMANT Address Mrs. Bertha M. Griffith, Keedysville, Rfd. 1			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardio-vascular DUE TO Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Pneumonia (b) Pneumonia DUE TO Pneumonia (c) Pneumonia						INTERVAL BETWEEN ONSET AND DEATH 8 yrs 8 mos 24 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 10, 1967 , to Nov 18, 1967 , that (I) (we) last saw the deceased alive on Nov. 17, 1967 , and that death occurred at 7 A M, from causes and on the date stated above.							
22a. SIGNATURE B. W. Helvan				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 11-19-67	
22c. PHYSICIAN'S NAME (Type) B. W. Helvan				22d. ADDRESS Boonsboro, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 11-22-67		23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery		23d LOCATION (City or Town) (County) (State) Boonsboro, Md.	
24. FUNERAL DIRECTOR ADDRESS John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.				25a REC'D BY REGISTRAR DATE NOV 24 1967		25b REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

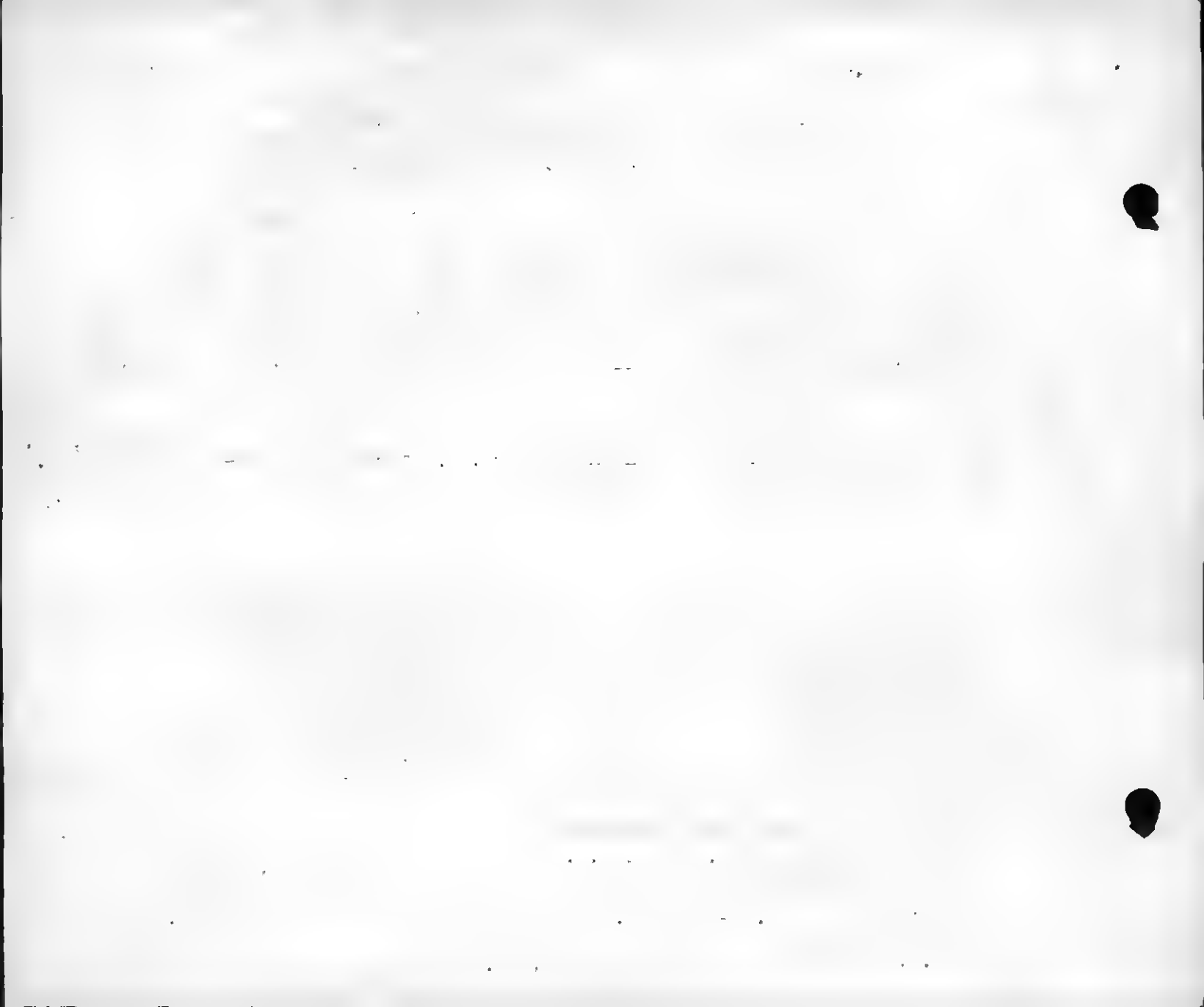
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10055

1 PLACE OF DEATH a COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c LENGTH OF STAY IN 1b 948 days	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL		d STREET ADDRESS 224 Patrick Street	
3. NAME OF DECEASED (Type or print) First KATHRYN Middle ELIZABETH Last GROVE		4. DATE OF DEATH Month 11 Day 2 Year 19 67	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH May 18, 1904
9 AGE (In years last birthday) yrs. 63		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY -----	11 BIRTHPLACE (County & State, or foreign country) Frederick, Maryland
12 CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Crum	
14 MOTHER'S MAIDEN NAME Mamie Schaefer		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO 214-10-1310		17 INFORMANT Address Frederick, Md. Mrs. R. Carroll Roderick-410 Delaware Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain tumor X O / X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 7 years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 'o m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 29, 1965 , to November 2, 1967 , that (I) (we) last saw the deceased alive on November 2, 1967 , and that death occurred at 7:15 AM , from causes and on the date stated above			
22a. SIGNATURE <i>Victor L. Ramos</i>		22b. DATE SIGNED 11/2/67	
22c. PHYSICIAN'S NAME (Type) Victor L. Ramos, M.D.		22d. ADDRESS Western Maryland State Hospital Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 6-1967	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Frederick, Md. 21701
24. FUNERAL DIRECTOR M.R. Etchison & Son		25a. REC'D BY REGISTRAR Nov 6 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

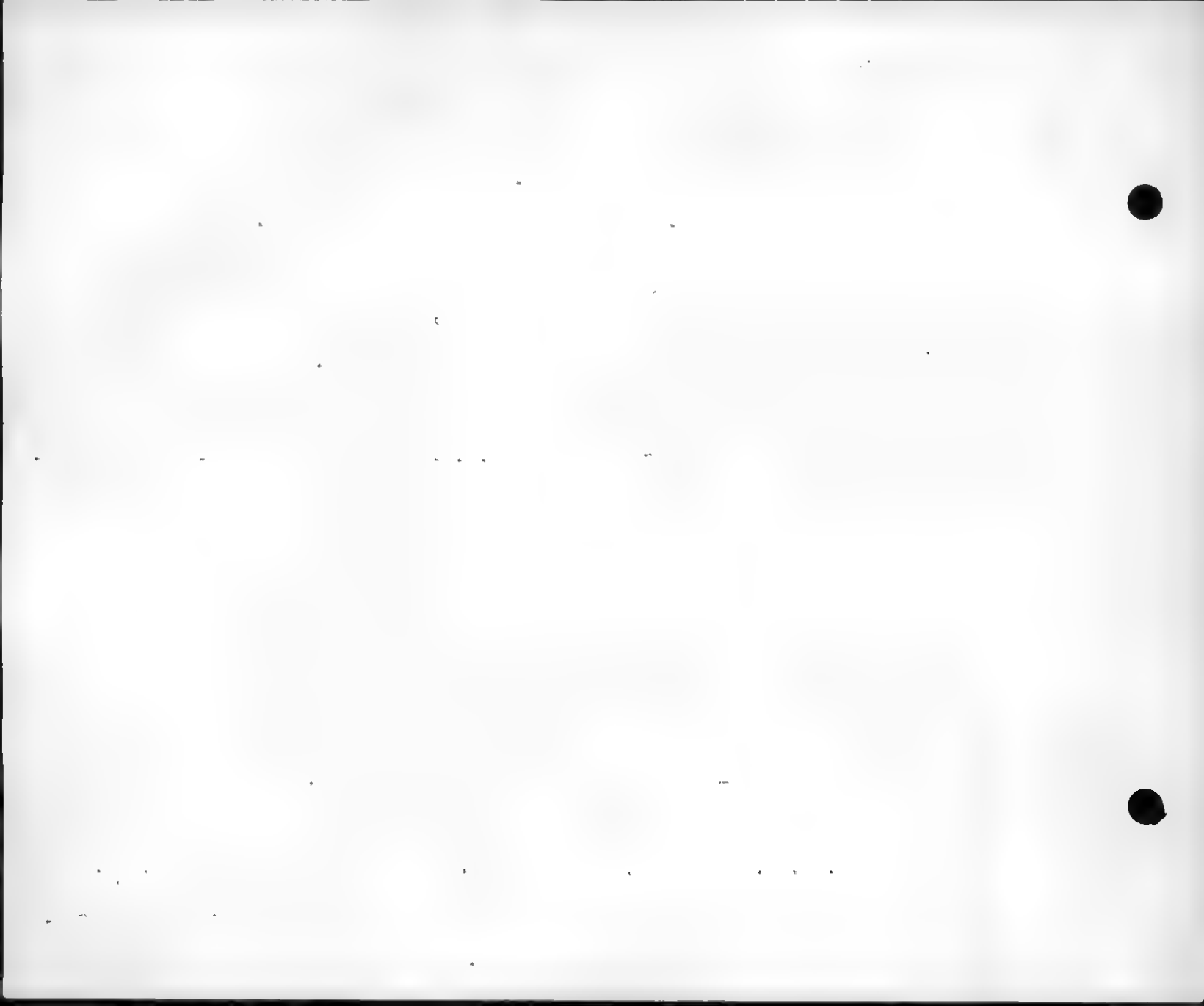
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10056

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY in <u>50 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>22 Winter St.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>22 Winter St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Isaac</u> Middle <u>Edward</u> Last <u>Gruber</u>			4. DATE OF DEATH Month <u>November</u> Day <u>10</u> Year <u>19 67</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 8, 1894</u>		9. AGE (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Drill Press Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dust Collecting Mfg</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Charlton, Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>John Ellsworth Gruber</u>				
14. MOTHER'S MAIDEN NAME <u>Susanna Martin</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes</u> <u>WWI</u>				
16. SOCIAL SECURITY NO. <u>214-09-2068</u>			17. INFORMANT Address <u>Mrs. J. E. Gruber 22 Winter St. Hagerstown, Md.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4301</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> (c) <u>Several years</u> (and trans, if any, which gave rise to immediate cause (a), stating the underlying cause lost)					INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>7-9-</u>, 19<u>67</u>, to <u>8-21-</u>, 19<u>67</u>, that (I) (we) last saw the deceased alive on <u>8-21-</u> 19<u>67</u>, and that death occurred at <u>10 P.M.</u> from causes and on the date stated above							
22a. SIGNATURE <u>J. E. W. Ditto, Jr.</u>					22b. DATE SIGNED <u>11-13-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>					22d. ADDRESS <u>215 W. Washington St., Hagerstown, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/14/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>			
24. FUNERAL DIRECTOR <u>Wm. C. Horn</u> ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>				25a. REC'D BY REGISTRAR <u>NOV 15 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

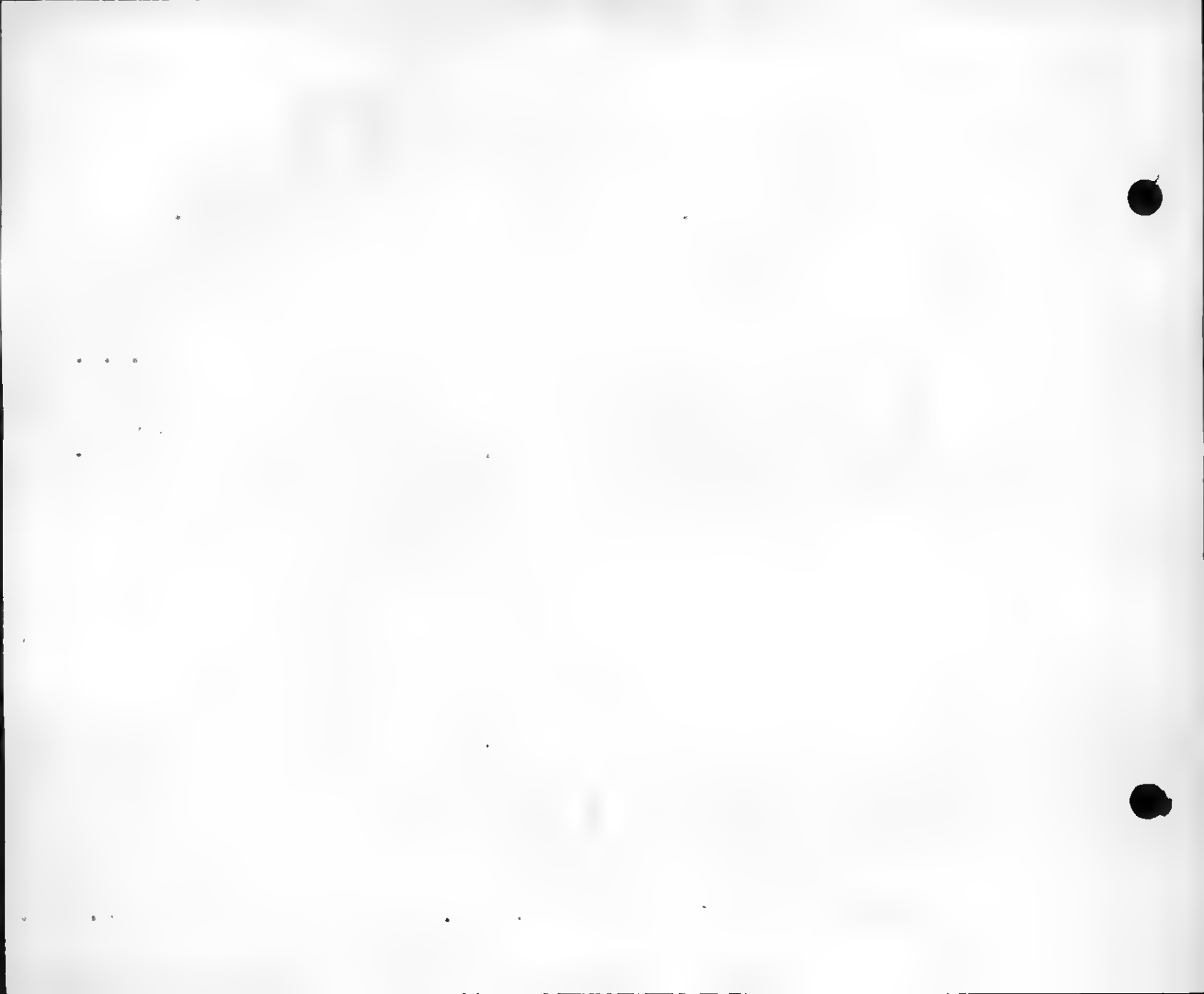
CERTIFICATE OF DEATH

16065

16057

1 PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 57 W. LONGMEADOW RD.		e. STREET ADDRESS 57 W. LONGMEADOW RD.	
3 NAME OF DECEASED (Type or print) First BROWNIE Middle LOUISE Last HAMILTON		4 DATE OF DEATH Month NOVEMBER Day 17 Year 1967	
5 SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4/28/1898
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11 BIRTHPLACE (County & State, or foreign country) VIRGINIA		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME JOHN WILLIAM CARTER		14. MOTHER'S MAIDEN NAME JOSEPHINE PIERCE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)		16 SOCIAL SECURITY NO. NONE	
17. INFORMANT MR. ROBERT EARL HAMILTON		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, Genl. & Cardiac DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 20 hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/30/1951 , to 11/17/1967 , that (I) (we) last saw the deceased alive on 11/16 1967 , and that death occurred at 3:55 PM , from causes and on the date stated above.			
22a. SIGNATURE Robert V. H. Campbell M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 11/17/67
22c. PHYSICIAN'S NAME (Type) Robert V. H. Campbell		22d. ADDRESS HAGERSTOWN MD	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF 11/20/67	23c NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	23d LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.
24 FUNERAL DIRECTOR J. J. Norment, Hagerstown Md.		25a REC'D BY REGISTRAR NOV 22 1967	25b REGISTRAR'S SIGNATURE Charles Judge

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RR



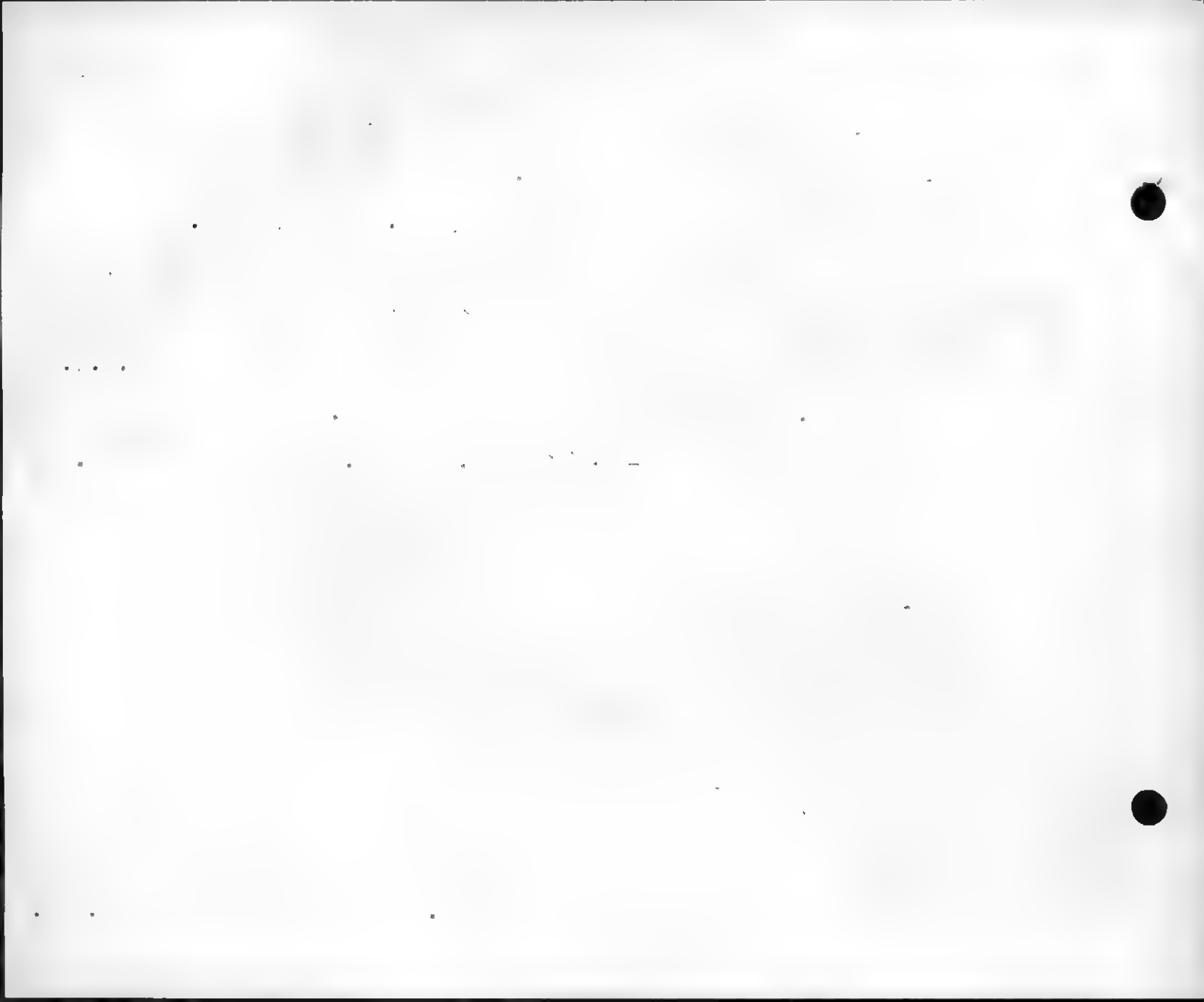
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

100663

10058

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 60 YRS.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				e. STREET ADDRESS 39 E. BALTIMORE ST.			
3. NAME OF DECEASED (Type or print) First Middle Last CLIFFORD VINTON HARBAUGH				4. DATE OF DEATH Month Day Year NOVEMBER 14 1967			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/22/1887	9. AGE (In years last birthday) 80 yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PLUMBER			10b. KIND OF BUSINESS OR INDUSTRY OWN BUSINESS		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME CLAYTON V. HARBAUGH				14. MOTHER'S MAIDEN NAME ALBERTA J. EYLER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 217-32-5410		17. INFORMANT Address HAGERSTOWN MD. MRS. MARY E. HARBAUGH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) Generalized atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Emphysema; Pneumonia; Hypertension							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 30 days , 19 66 , to date , 19 67 , that (I) (we) last saw the deceased alive on 13 Nov 67 , and that death occurred at 24 M, from causes and on the date stated above.							
22a. SIGNATURE Richard T. Binford		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 14 Nov. 67			
22c. PHYSICIAN'S NAME (Type) Richard T. Binford, M. D.		22d. ADDRESS 1135 Potomac Avenue Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL, etc. BURIAL		23b. DATE THEREOF 11/16/67		23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.		23d. LOCATION (City or town) (County) (State) HAGERSTOWN WASH. MD.	
24. FUNERAL DIRECTOR W. J. Perment, Hagerstown, Md.				25a. REC'D BY REGISTRAR DATE NOV 20 1967		25b. REGISTRAR'S SIGNATURE Richard J. Judge	



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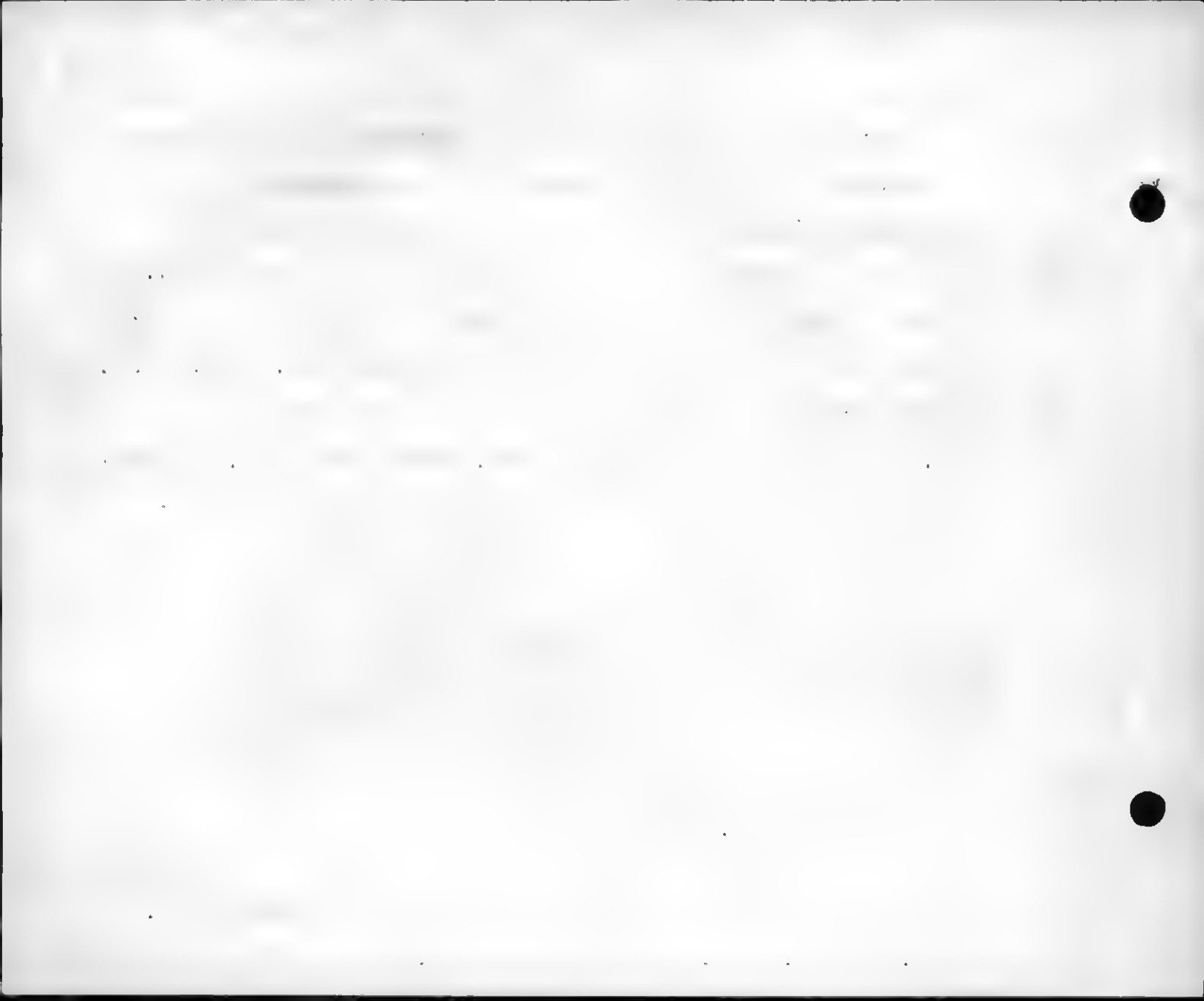
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

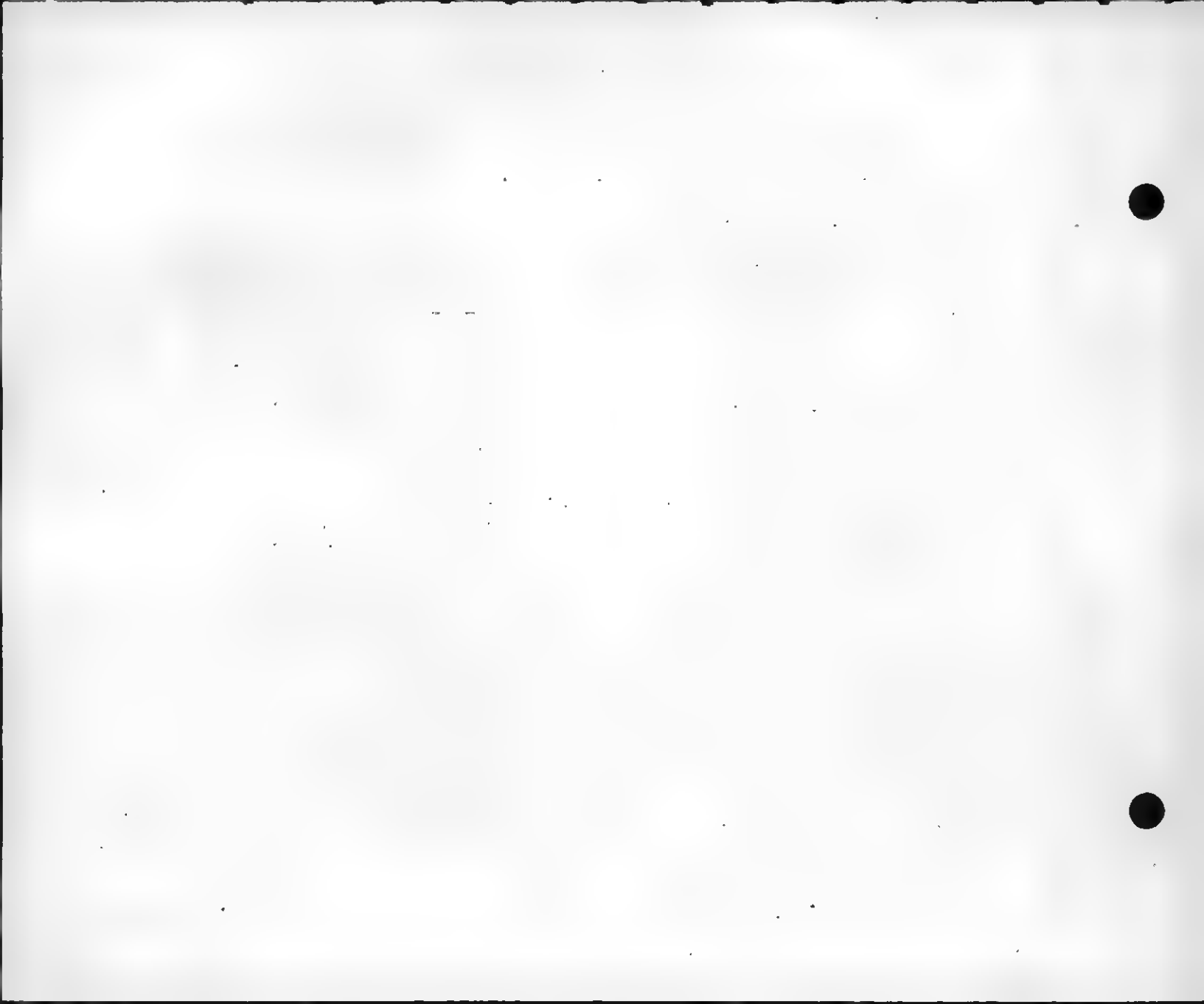
16059

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro				c. LENGTH OF STAY IN 1b 5 Months			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Reeder Nursing Home				e. STREET ADDRESS Chestnut Grove			
3. NAME OF DECEASED (Type or print) First Middle Last Bruce William Hardey				4. DATE OF DEATH Month Day Year November 11, 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1885	9. AGE (In years last birthday) 82 yrs	10. IF UNDER 1 YEAR Months Days Hours Min. 6 9		11. IF UNDER 24 HRS Hours Min. 9
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (County & State, or foreign country) Weavertown, Wash. Co., Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Hardey				14. MOTHER'S MAIDEN NAME Helen Fitzspatrick			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 220-09-9137		17. INFORMANT Mrs. Hyliene Tusing, Rfd. 1 Boonsboro, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis with Hemiplegia 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertensive C.V. Dis. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Decubitus Ulcers						INTERVAL BETWEEN ONSET AND DEATH 3 mo. 2 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-1-67 , 19 67 , to 10-11 , 19 67 , that (I) (we) last saw the deceased alive on 10-11 , 19 67 , and that death occurred at 6 P M, from causes and on the date stated above.							
22a. SIGNATURE Robert P. Conrad M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 11-13-67	
22c. PHYSICIAN'S NAME (Type) Robert P. Conrad, M.D.				22d. ADDRESS 137 W. Washington Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-14-67		23c. NAME OF CEMETERY OR CREMATORY Brownsville Hgts. Cem.		23d. LOCATION (City or Town) (County) (State) Brownsville, Md.	
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.				25a. REC'D BY REGISTRAR NOV 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



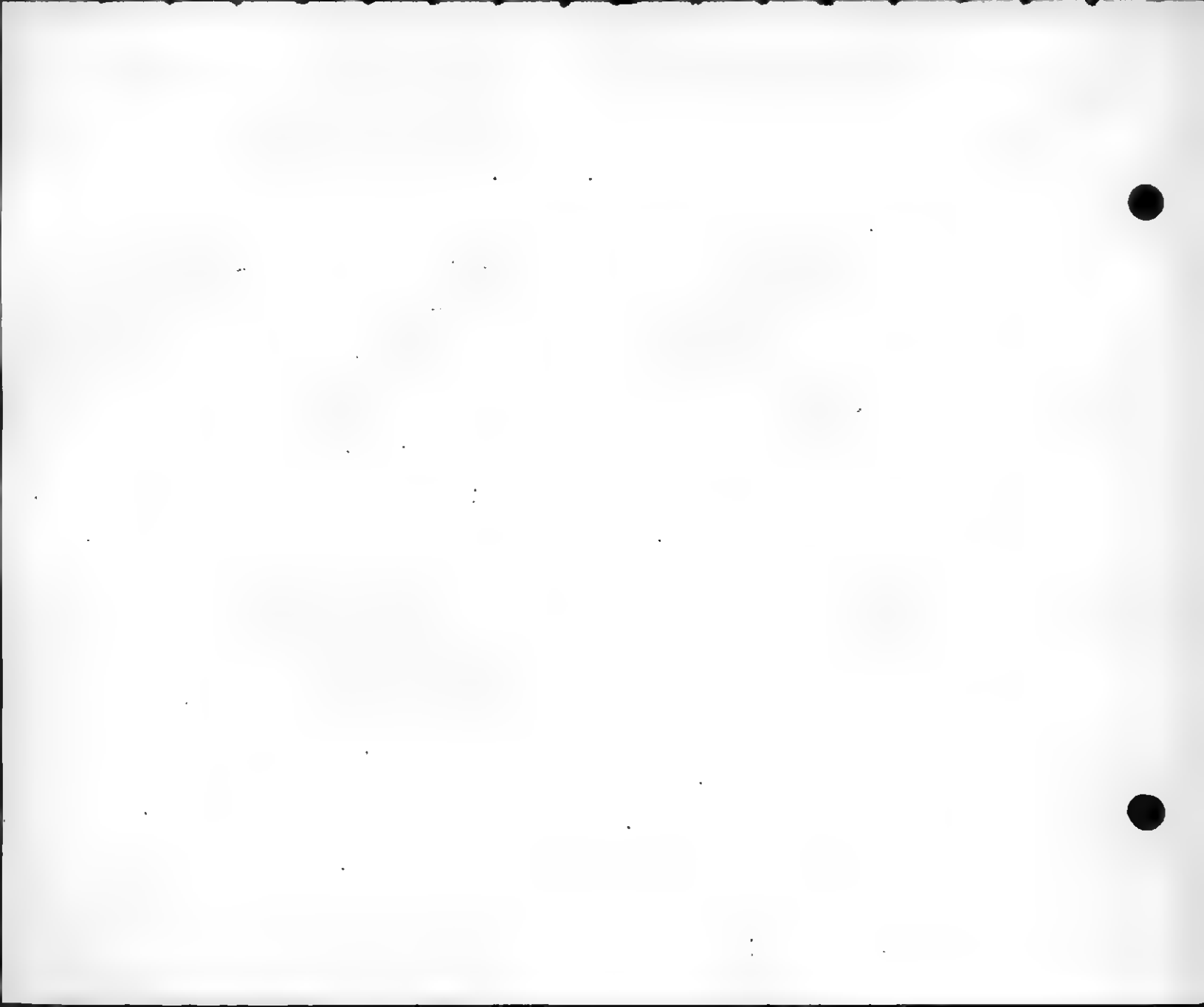
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND Items 2 & 3 taken from birth certificate											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>9 hrs. 10 min.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> d. STREET ADDRESS <u>Route #2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>Twin I</u> First <u>James</u> Middle <u>Lee</u> Last <u>Hastings</u>			4. DATE OF DEATH <u>November 29</u> 19 <u>67</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <u>11-29-67</u>			9. AGE (In years last birthday) <u>9</u> yrs. <u>10</u> Months <u>9</u> Days <u>10</u> Hours <u>10</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Washington Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Josiah Thurle Hastings</u>			14. MOTHER'S MAIDEN NAME <u>Shirley Ann Palmer</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>Medical Records</u>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fetal Abortion</u> DUE TO (b) <u>Amniotic Band Twin (1 lb 13 1/2 g)</u> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH <u>9 hrs 10 min</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>11/29/</u> , 19 <u>67</u> , to <u>11/29/</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/29/</u> 19 <u>67</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above.		
22a. SIGNATURE <u>A.M. Bacon, Jr.</u>			22b. DATE SIGNED <u>12-20-67</u>		22c. PHYSICIAN'S NAME (Type) <u>A.M. BACON, JR., M.D.</u>		22d. ADDRESS <u>101 KING ST., HAGERSTOWN, MD.</u>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF <u>Dec. 21, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON COUNTY HOSPITAL HAGERSTOWN, MARYLAND</u>		23d. LOCATION (City, town or county) (State)		24. FUNERAL DIRECTOR <u>John Schaffer adm. Wash G. Hoff</u>		
25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		25c. DATE <u>DEC 27 1967</u>		25d.		25e.		



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
<div style="display: flex; justify-content: space-between;"> <div> <p>10069</p> <p>Items 2 & 3 taken from birth certificate 12/27/67 kk</p> </div> <div> <p>CERTIFICATE OF DEATH</p> <p>1-730</p> </div> </div>										
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>8 hrs. 41 min.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>			d. STREET ADDRESS <u>Route #2</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Twin II</u> First <u>John</u> Middle <u>Lynn</u> Last <u>Hastings</u>					4. DATE OF DEATH Month <u>November</u> Day <u>29</u> Year <u>1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-29-67</u>		9. AGE (in years last birthday) <u>8</u> <u>41</u> yrs. IF UNDER 1 YEAR: Months <u>8</u> Days <u>41</u> Hours <u>41</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Washington Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Josiah Thurlie Hastings</u>					14. MOTHER'S MAIDEN NAME <u>Shirley Ann Palmer</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Medical Records</u>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fetal Abortion</u> DUE TO (b) <u>Immature Birth Twin (1 lb 14 g.)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs 41 min</u> <u>Some</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>11/29/1967</u> to <u>11/29/1967</u> , that (I) (we) last saw the deceased alive on <u>11/29/1967</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.										
22a. SIGNATURE <u>A.M. Bacon</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/20/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>A.M. BACON, M.D.</u>					22d. ADDRESS <u>101 KING ST., HAGERSTOWN, M.D.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Dec. 21, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON COUNTY HOSPITAL</u>		23d. LOCATION (City, town or county) (State) <u>HAGERSTOWN, MARYLAND</u>				
24. FUNERAL DIRECTOR <u>John Schroffer</u>					ADDRESS <u>Adm. Wash Co Hosp</u>		25a. REC'D BY REGISTRAR <u>DEC 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>W. J. Judge</u>	



FOR STATE
HEALTH DEPT.

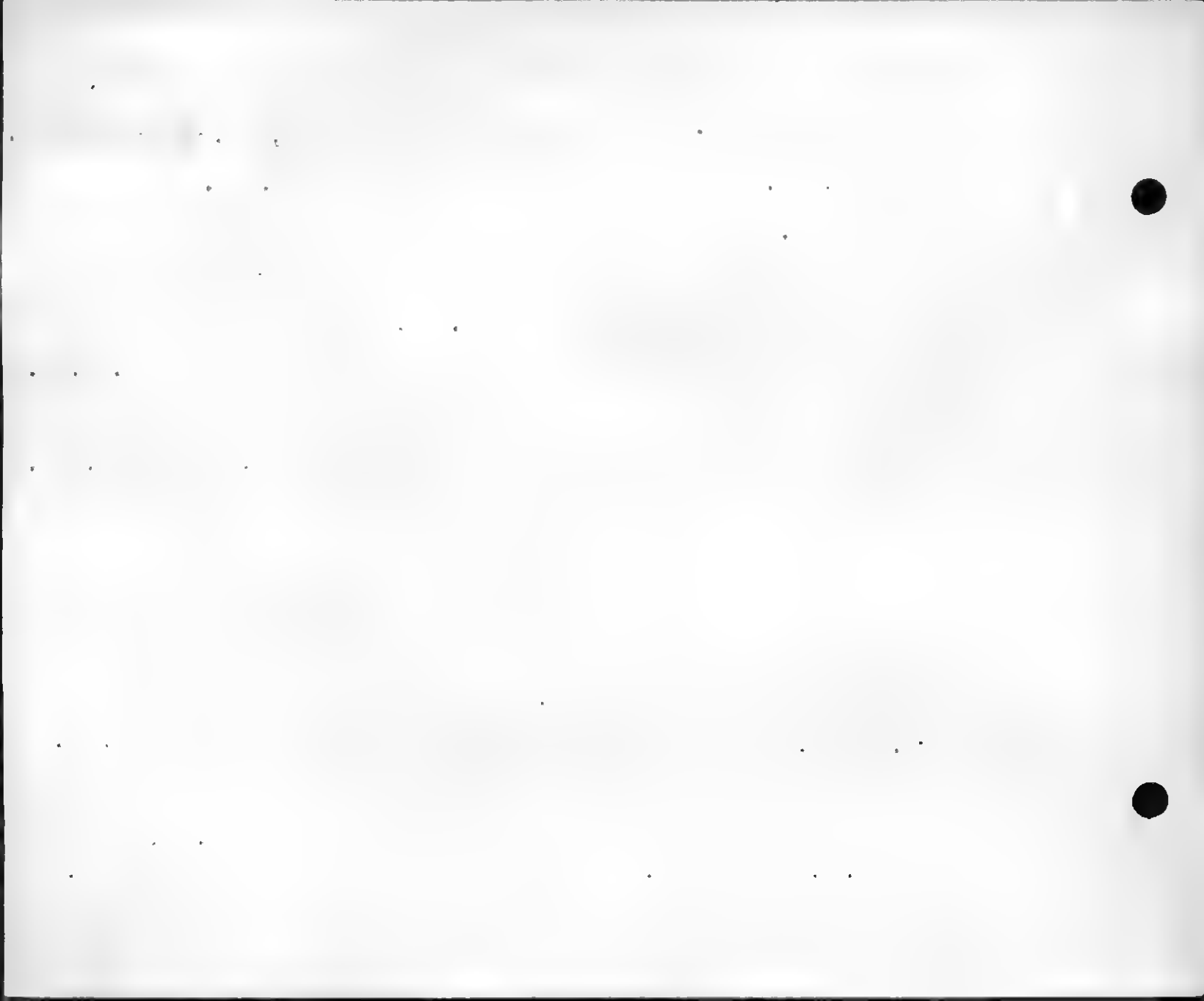
TO DEPUTY MEDICAL EXAMINER: This certificate should be submitted with in 14 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with four copies. 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10000

1. PLACE OF DEATH a. COUNTY Washington Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.				c. LENGTH OF STAY IN TB 4 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Co. Hospital				e. STREET ADDRESS None			
3. NAME OF DECEASED (Type or print) First Grace Middle Marie Last Herron				4. DATE OF DEATH Month November Day 19 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20, 1903	9. AGE (In years last birthday) 64 YRS	F UNDER 1 YEAR Months 6 Days 19		F UNDER 24 HRS Hours 67 Min 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Nathan Herron			14. MOTHER'S MAIDEN NAME Rebecca McCray				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Janice Taulton Rt#2, Knoxville, Md.		Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO 7200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Emphysema DUE TO (c) Fracture Of Arm & Ribs INTERVAL BETWEEN ONSET AND DEATH Several years 2 months							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fell in home							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Fell in home				
20c. TIME OF INJURY Month, Day, Year Hour a.m. P.M. Sept. 20, 1967			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Brunswick, Frederick, Md.	
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE [Signature] EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.			22. DATE SIGNED Nov. 21, 67 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 11-24-67	23c. NAME OF CEMETERY OR CREMATORY Washington Co. Hospital		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.		23e. REC'D BY REGISTRAR [Signature]	23f. REGISTRAR'S SIGNATURE [Signature]
24. FUNERAL DIRECTOR [Signature]			ADDRESS [Address]		DATE NOV 24 1967		[Signature]



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

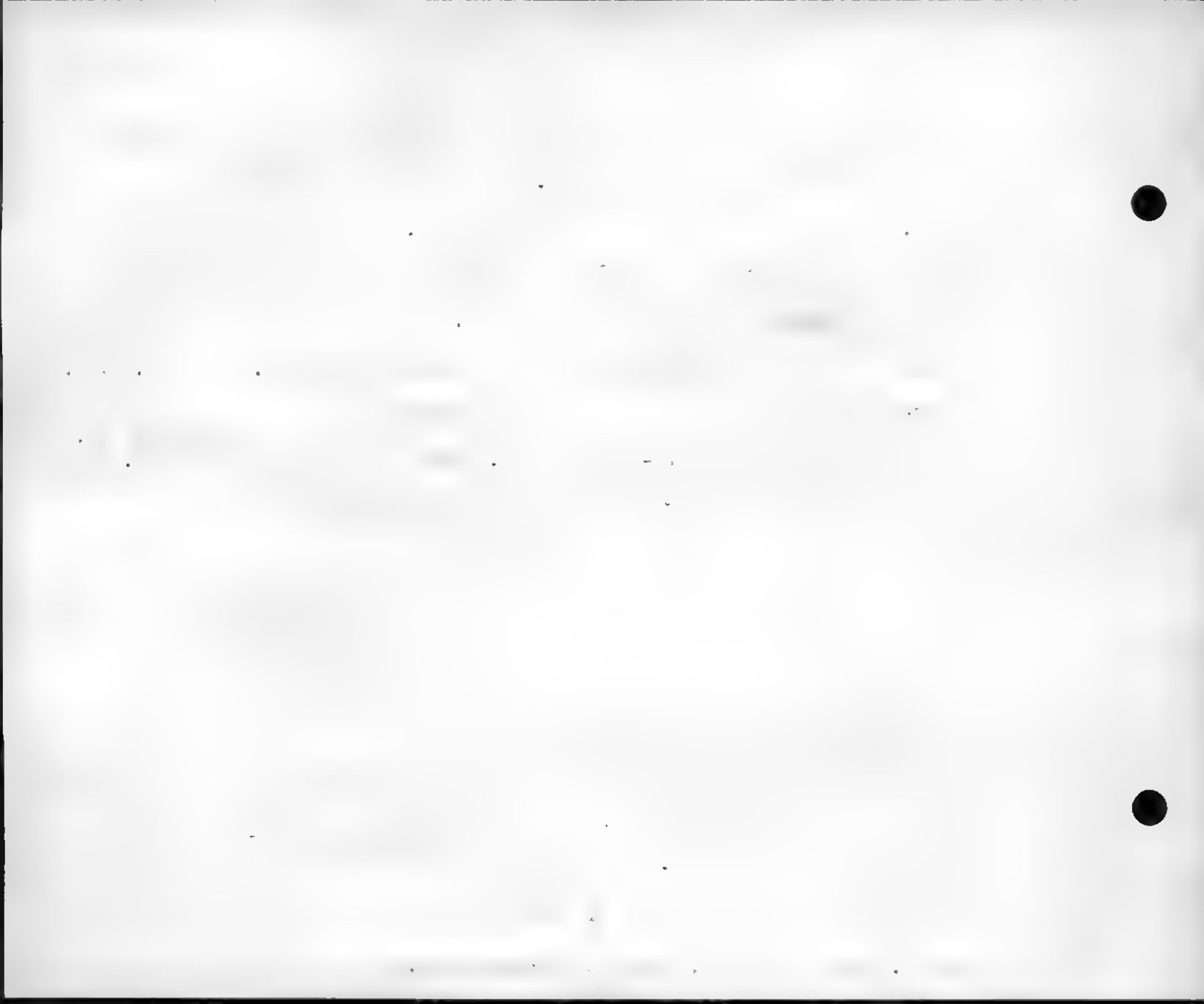
CERTIFICATE OF DEATH

16061

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Boonsboro		c. LENGTH OF STAY IN 1b 11 Yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rfd. 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Daisy Viola Hill		4. DATE OF DEATH Month Day Year November 13, 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 15, 1893
9. AGE (in years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min 11 28	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Orphans Home	
11. BIRTHPLACE (County & State, or foreign country) Beaver Creek, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Hill		14. MOTHER'S MAIDEN NAME Mary Bear	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 217-32-7447	
17. INFORMANT Boonsboro, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease DUE TO (b) Disease DUE TO (c) 15 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HDW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 13, 1967 to Nov 13, 1967 that (I) (we) last saw the deceased alive on Nov 13, 1967 , and that death occurred at 4 P. M, from causes and on the date stated above.			
22a. SIGNATURE G. W. Hill M.D.		22b. DATE SIGNED Nov 14, 67	
22c. PHYSICIAN'S NAME (Type) G. W. Hill		22d. ADDRESS Boonsboro, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-16-67	23c. NAME OF CEMETERY OR CREMATORY Cemetery	23d. LOCATION (City or Town) (County) (State) Beaver Creek, Md
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		25a. REC'D BY REG STRAR NOV 21 1967	
25b. REGISTRAR'S SIGNATURE Richard Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

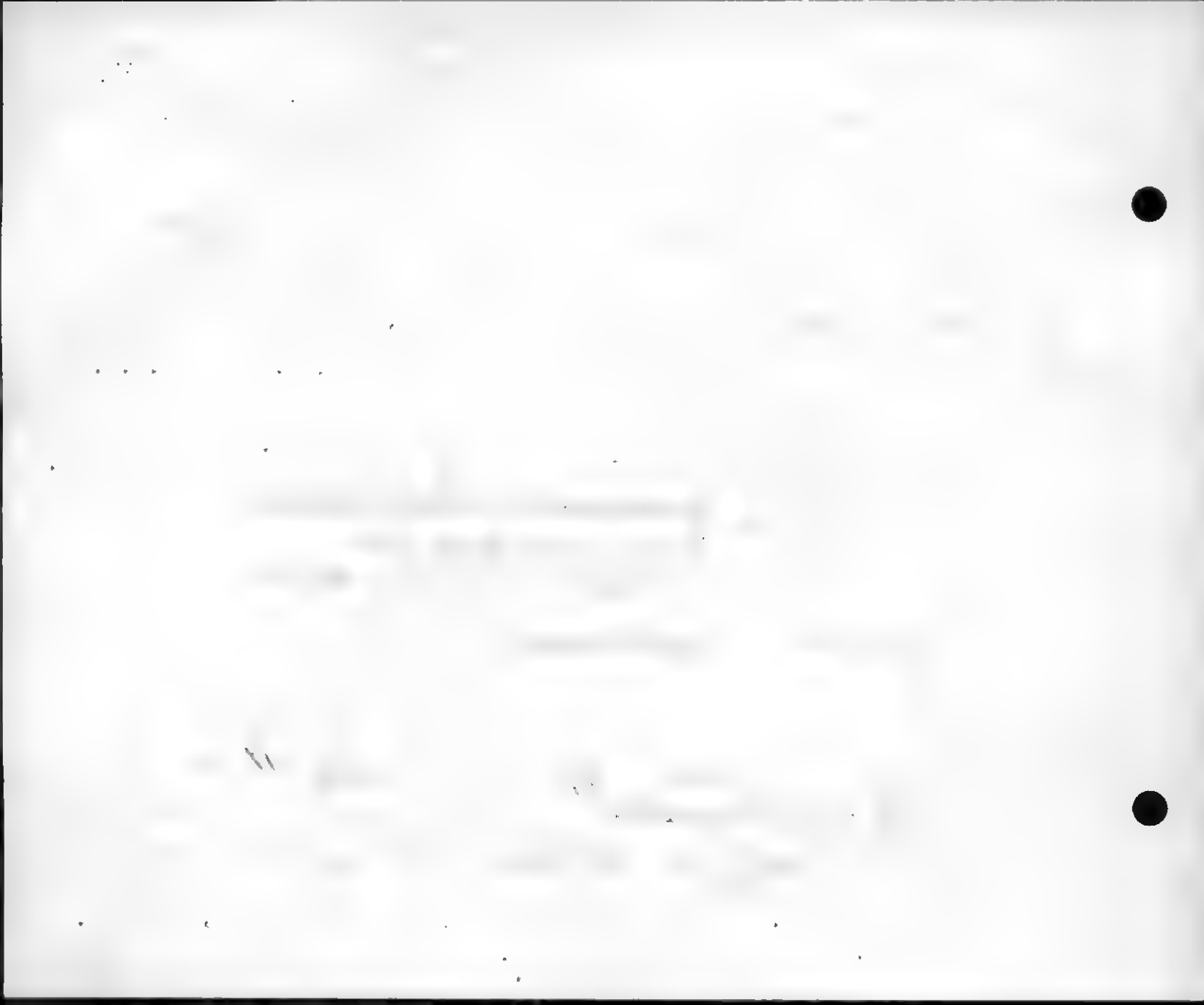
13382

16072

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 4 Weeks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. STREET ADDRESS 121 South Locust Street	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Adine Hines		4. DATE OF DEATH Month Day Year November 10, 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1893
9. AGE (in years lost birthday) yrs 75		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Bingo	
11. BIRTHPLACE (County & State, or foreign country) Keedysville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Owen Kretzer		14. MOTHER'S MAIDEN NAME Ananda E. Bizer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-05-6782	
17. INFORMANT Miss Juamta Roby Funkstown, Maryland.		Address 4 W. West Side Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction due to Coronary Thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arteriosclerotic Heart D DUE TO (c) Hypertensive Card-Vas. Disease			INTERVAL BETWEEN ONSET AND DEATH 10-10-67
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension, Hypochloremia			19. WAS A TOLPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10-10 , 19 67 to 11-10 , 19 67 that (I) (we) last saw the deceased alive on 11-10 , 19 67 , and that death occurred at 2:40 M, from causes and on the date stated above.			
22a. SIGNATURE Sidney Horvath		22b. DATE SIGNED 11-10-67	
22c. PHYSICIAN'S NAME (Type) SIDNEY HORVATH		22d. ADDRESS FUNKSTOWN MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 11, 1967	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown, Maryland.
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc.		25a. REC'D BY REGISTRAR NOV 13 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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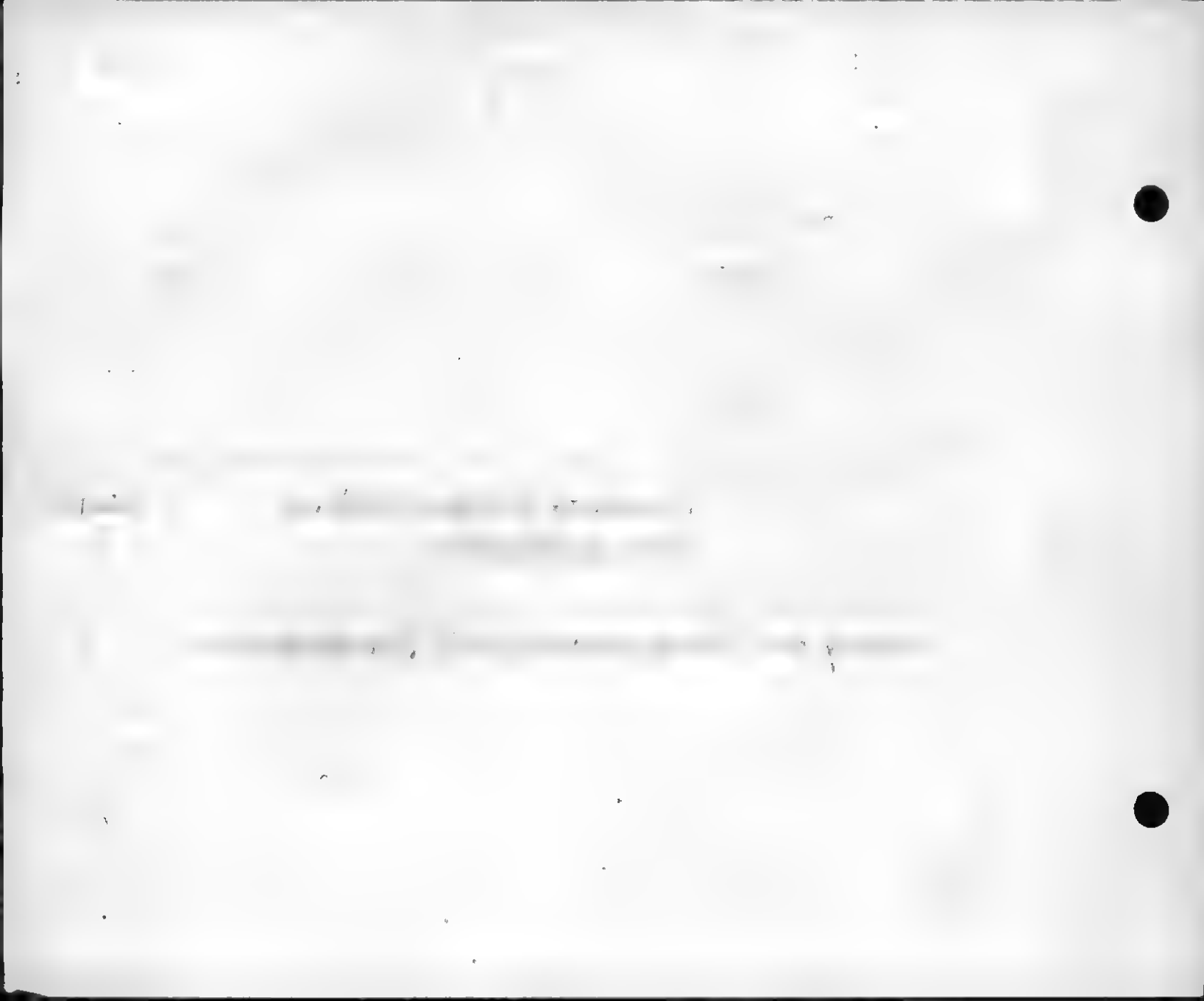
16073

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15083

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Franklin ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Box 1945, Hagerstown		c. LENGTH OF STAY IN 1b 37 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route #3, Greencastle 753		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Brook Lane Psychiatric Center		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last David LESLIE Hissong		4. DATE OF DEATH Month Day Year November 9 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/15/91
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Dairy farming	
11. BIRTHPLACE (County & State, or foreign country) Franklin County, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME David H. Hissong		14. MOTHER'S MAIDEN NAME Ellie Keefer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 204-40-3944	
17. INFORMANT Fannie Hissong, Route #3, Greencastle, Pa.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus, bilateral DUE TO (b) Thrombophlebitis DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary occ. - old myocardial infarct - Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 11/3/67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from October 3, 1967 , to November 9, 1967 , that (I) (we) last saw the deceased alive on Nov. 9 1967 , and that death occurred at 6:30 A.M. from causes and on the date stated above.			
22a. SIGNATURE Paul Saraduke		22b. DATE SIGNED 11/9/67	
22c. PHYSICIAN'S NAME (Type) Paul Saraduke, M.D.		22d. ADDRESS Brook Lane Psychiatric Center	
23a. BURIAL (CREMATION, REMOVAL) (Specify) 11/12/67		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Fairview Cem.		23d. LOCATION (City or Town) (County) (State) Mercersburg, Pa.	
24. FUNERAL DIRECTOR W. H. Leninger		25a. REC'D BY REGISTRAR NOV 13 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10064

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Wash. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 56 Years.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. STREET ADDRESS 430 E. Franklin St.	
3 NAME OF DECEASED (Type or print) First Arthur Middle NMN Last Hoffman, Sr.		4. DATE OF DEATH Month November Day 20 , Year 1967	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-31-91
9. AGE (In years last birthday) 76 yrs		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY construction C.	
11. BIRTHPLACE (County & State, or foreign country) Beaver Creek, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hiram H. Hoffman		14. MOTHER'S MAIDEN NAME Susan Reese	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 214-09-2312	
17. INFORMANT Arthur Hoffman, Jr., Hagerstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Carcinoma, abdominal 157. DUE TO (b) Carcinoma Pancreas Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 1 yr		INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/23 , 19 67 , to 11/20 , 19 67 , that (I) (we) last saw the deceased alive on 11/20 , 19 67 , and that death occurred at 10:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Robert V. H. Campbell M.D.		22b. DATE SIGNED 11/21/67	
22c. PHYSICIAN'S NAME (Type) Robert V. H. Campbell		22d. ADDRESS HAGERSTOWN Md	
23a. BURIAL, CREMATION, REMOVAL, etc. Burial	23b. DATE THEREOF 11-22-67	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REG'D BY REGISTRAR DATE NOV 24 1967	
		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.



1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

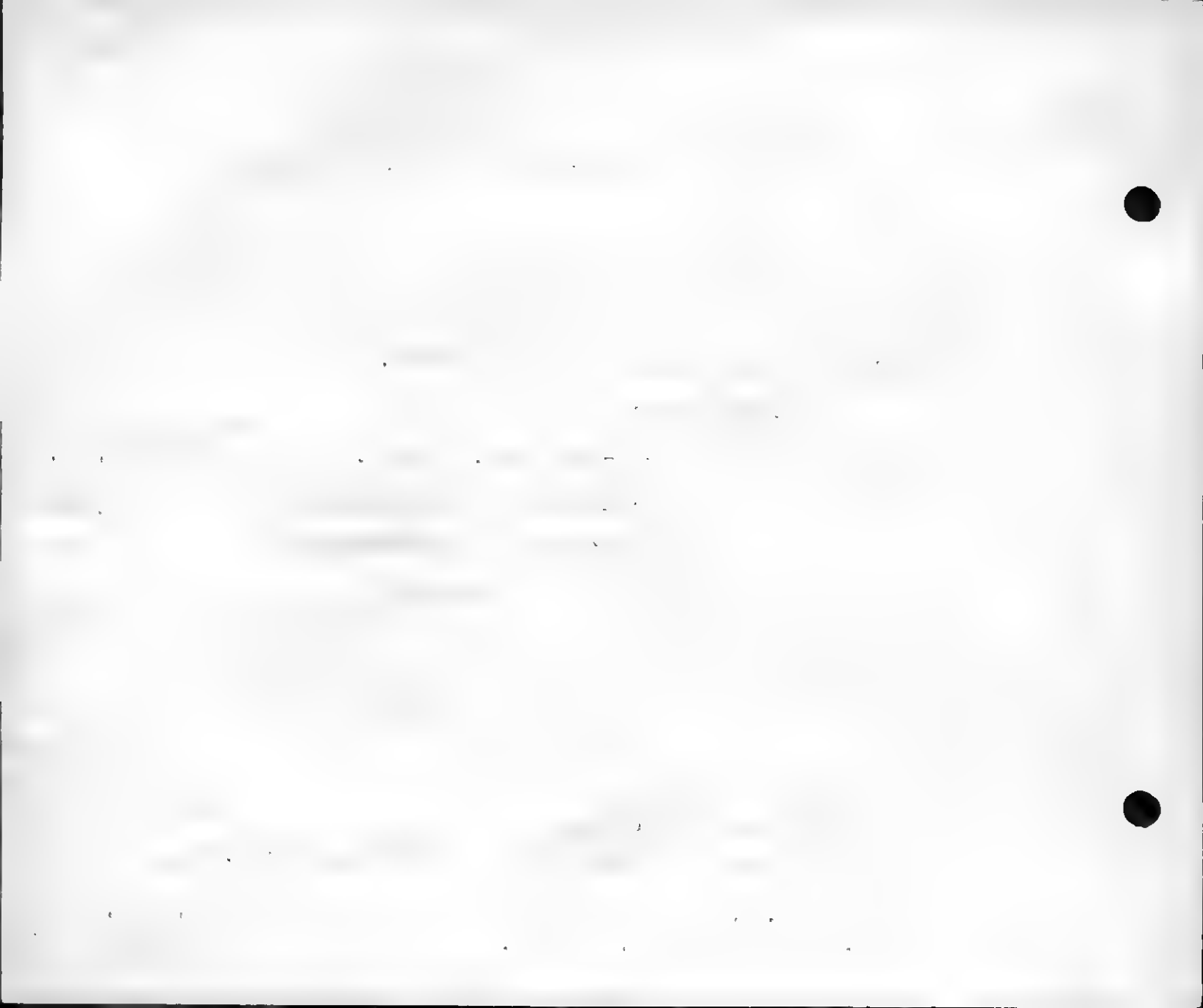
10065

16075

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

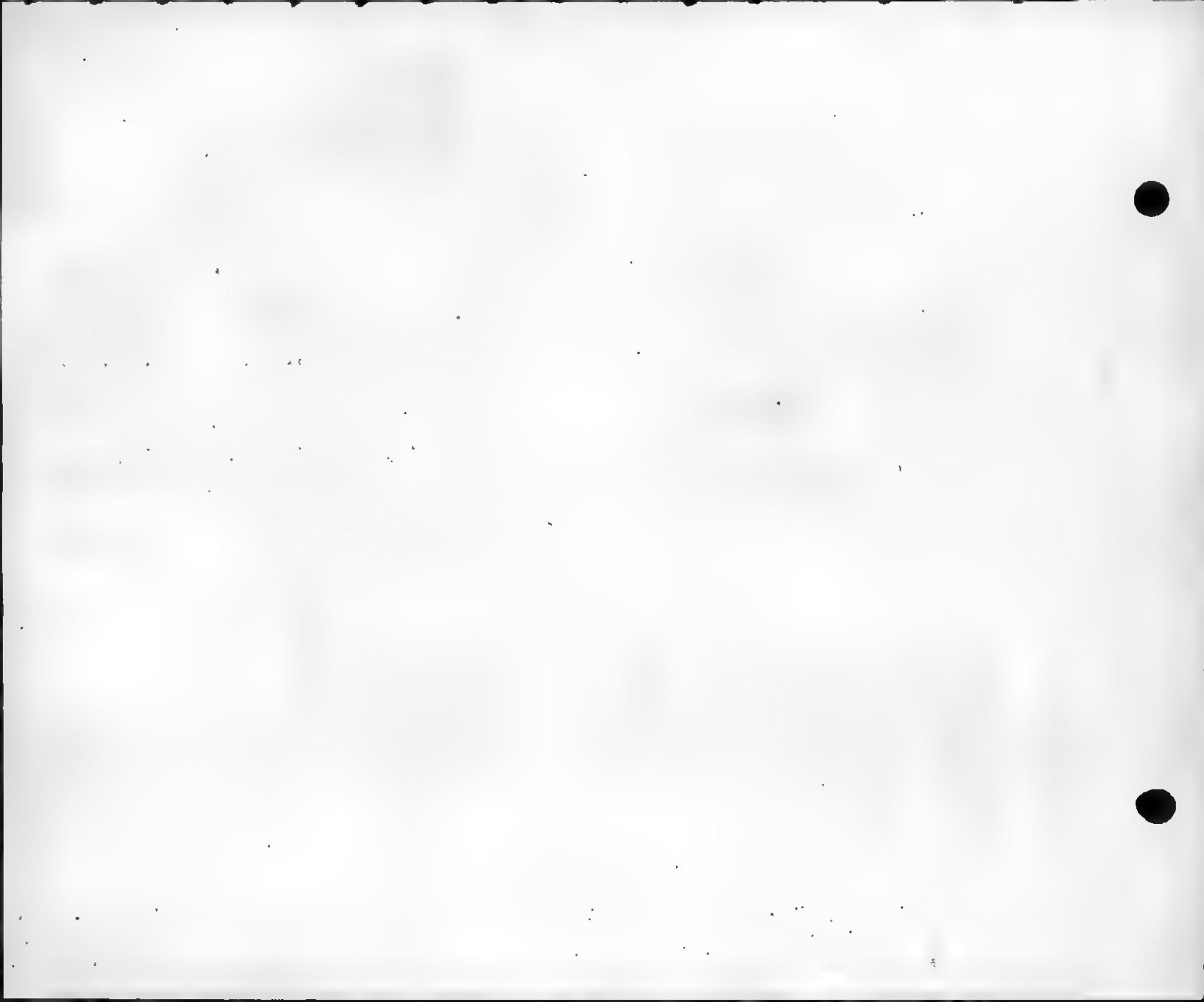
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 6 months	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Williamsport
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL		d. STREET ADDRESS 7-79 VIRGINIA AVE. WILLIAMSPORT	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF (Type or print) JOSEPH MCKINLEY HOFFMAN		4. DATE OF DEATH Month NOVEMBER Day 24 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-26-97
9. AGE (In years lost birthday) 69 yrs		10. IF UNDER 1 YEAR Months 11 Days 3 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Well Driller		10b. KIND OF BUSINESS OR INDUSTRY Water Well Drilling Penna.	
11. BIRTHPLACE (County & State, or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Clinton Hoffman		14. MOTHER'S MAIDEN NAME ALICE Myers	
15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-14-6048	
17. INFORMANT Mrs. Joseph M. Hoffman		18. ADDRESS 2719 Virginia Ave. Williamsport, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Lobular pneumonia DUE TO Cerebral thrombosis DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH 1 wk 7 mons ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-24 , 19 67 , to 11-20 , 19 67 , that (I) (we) last saw the deceased alive on 11-20 , 19 67 , and that death occurred at 10:25 A.M. from causes and on the date stated above			
22a. SIGNATURE Edwin G. Riley		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Edwin G. Riley		22d. ADDRESS 1500 Penna, Hagerstown, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 2, 1967	23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery	23d. LOCATION (City or Town) (County) (State) Williamsport, Wash., Maryland
24. FUNERAL DIRECTOR Albert L. Leaf Williamsport, Maryland.		25a. REC'D BY REGISTRAR DEC 4 1967	
		25b. REGISTRAR'S SIGNATURE William J. Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN ID <u>1 Day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clear Spring</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Strite</u> Last <u>Horst</u>						4. DATE OF DEATH Month <u>Nov.</u> Day <u>24th</u> Year <u>1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 12, 1891</u>		9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Abram Strite Horst</u>						14. MOTHER'S MAIDEN NAME <u>Fannie C. Strite</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>						16. SOCIAL SECURITY NO. <u>212-24-3167</u>		17. INFORMANT <u>John Horst</u>		Address <u>Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 day</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 24, 1967</u> to <u>Nov 24, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov 24, 1967</u> , and that death occurred at <u>1:30</u> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Charles C. Spencer</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Nov. 26 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>Charles C. Spencer</u>						22d. ADDRESS <u>145 S. Prospect St. Hagerstown Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Nov. 27, 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Clear Spring Mennonite</u>		23d. LOCATION (City, town or county) (State) <u>Clear Spring Wash. Md.</u>			
24. FUNERAL DIRECTOR <u>Donald E. Thompson</u>						ADDRESS <u>Thompson Funeral Home</u>		25a. REC'D BY REGISTRAR <u>DEC 5 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



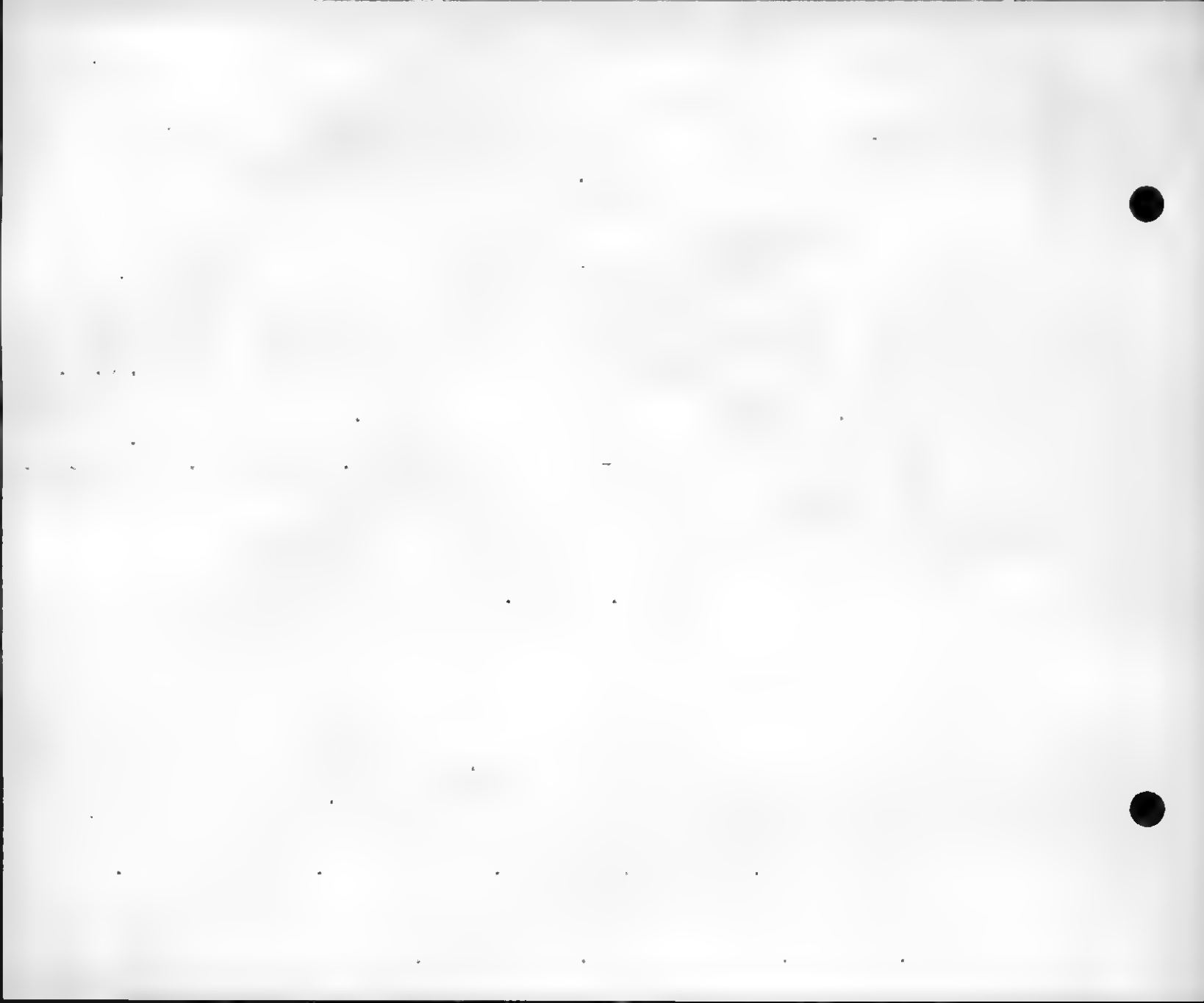
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 Hr.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS Rfd. 2	
3. NAME OF DECEASED (Type or print) First Middle Last Myrtle Katherine Irving		4. DATE OF DEATH Month Day Year November 14, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 28, 1900
9. AGE (In years last birthday) 67 yrs		10. IF UNDER 1 YEAR Months Days Hours Min 6 16	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Daniel T. Lantz		14. MOTHER'S MAIDEN NAME Annie I. Miller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO 212-50-8307	
17. INFORMANT Mr. Clarence E. Irving, Rfd. 2, Boonsboro, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerotic Cardio Vascular Disease DUE TO (c) Diabetes. Obesity.		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hours Several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 9, 1967 , to Nov. 14, 1967 , that (I) (we) last saw the deceased alive on Nov. 14, 1967 , and that death occurred at 1:15 M, from causes and on the date stated above			
22a. SIGNATURE J. W. Ditto, Jr. M.D.		22b. DATE SIGNED 11-15-67	
22c. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.		22d. ADDRESS 215 W. Washington St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-17-67	23c. NAME OF CEMETERY OR CREMATORY Beaver Creek Cemetery	23d. LOCATION (City or Town) (County) (State) Beaver Creek, Md.
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		25a. REC'D BY REGISTRAR NOV 21 1967	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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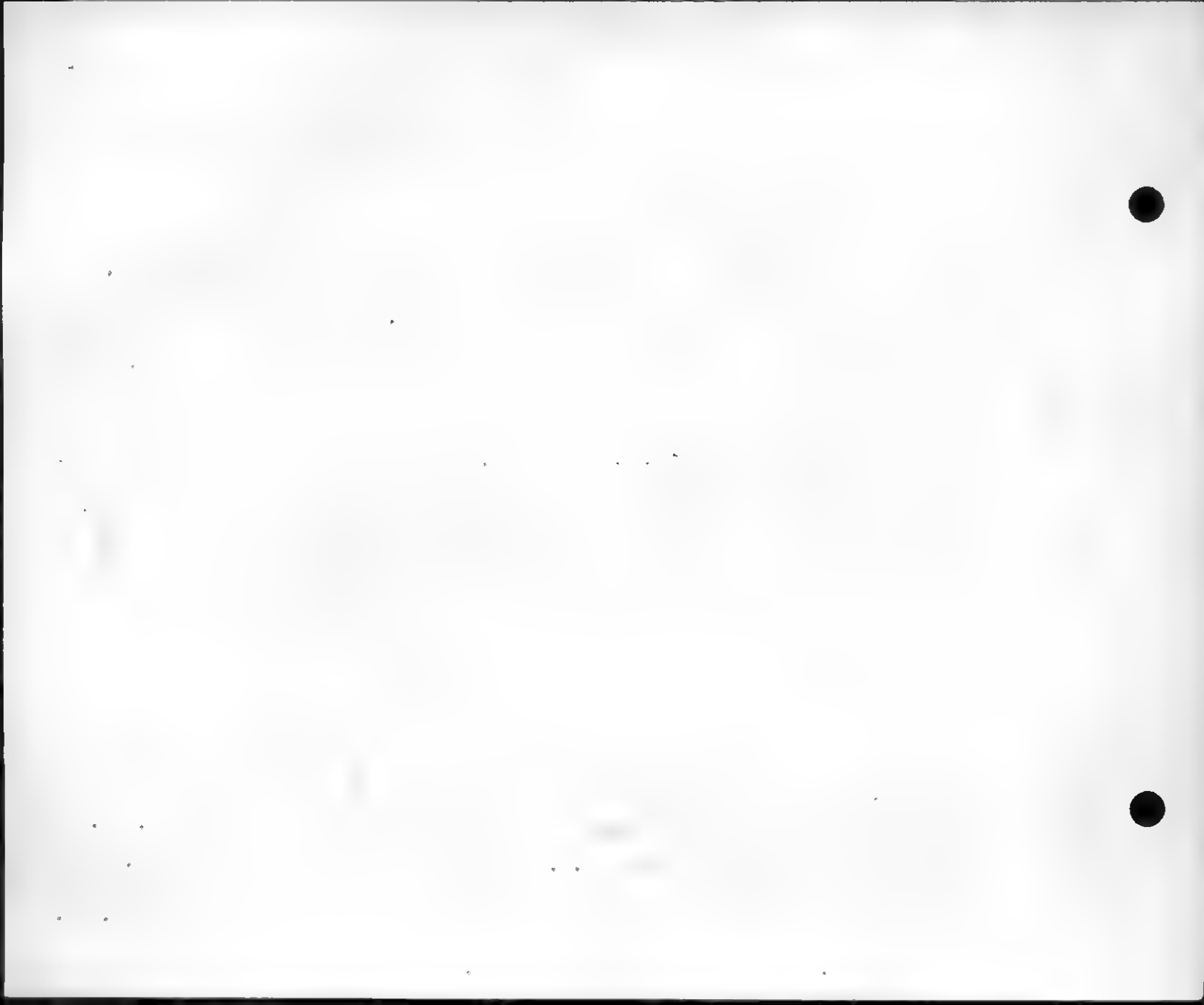
16078

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16008

1 PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 37 YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 526 EAST WILSON BLVD.		e. STREET ADDRESS 526 EAST WILSON BLVD.	
3. NAME OF DECEASED (Type or print) First AMELIA Middle CATHERINE Last JOLY		4 DATE OF DEATH Month NOVEMBER Day 24 Year 1967	
5 SEX FEMALE	6. COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 26, 1894
9 AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 8 Days 4 Hours 24 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED COOK		10b. KIND OF BUSINESS OR IND. STRY RESTAURANT	
11 BIRTHPLACE (County & State, or foreign country) WASHINGTON CO. MARYLAND.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HUNTER TURNER		14 MOTHER'S MAIDEN NAME SARAH E. RIDENOUR	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO *****		16 SOCIAL SECURITY NO. 214-09-5076	
17 INFORMANT MR. LEO T. JOLY,		526 EAST WILSON BLVD. HAGERSTOWN, MARYLAND.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arterio sclerotic Heart Disease DUE TO (c) Hypertensive Vascular Disease			INTERVAL BETWEEN ONSET AND DEATH 1 hr. 8 mo. 14 yrs.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) W. H. HOFFMAN attended the deceased from Aug. , 19 60 , to NOV 24 , 1967 that (I) XX saw the deceased alive on Nov 24 1967, and that death occurred at 9:15 A.M. from causes and on the date stated above.			
22a. SIGNATURE Lloyd A. Hoffman M.D.		22b. DATE SIGNED NOV. 25. 1967	
22c. PHYSICIAN'S NAME (Type) LLOYD A. HOFFMAN, M.D.		22d. ADDRESS 214 N. POTOMAC ST. HAGERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 11/28/67	23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY	23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD.
24 FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.		25a. REC'D BY REGISTRAR DATE NOV 30 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



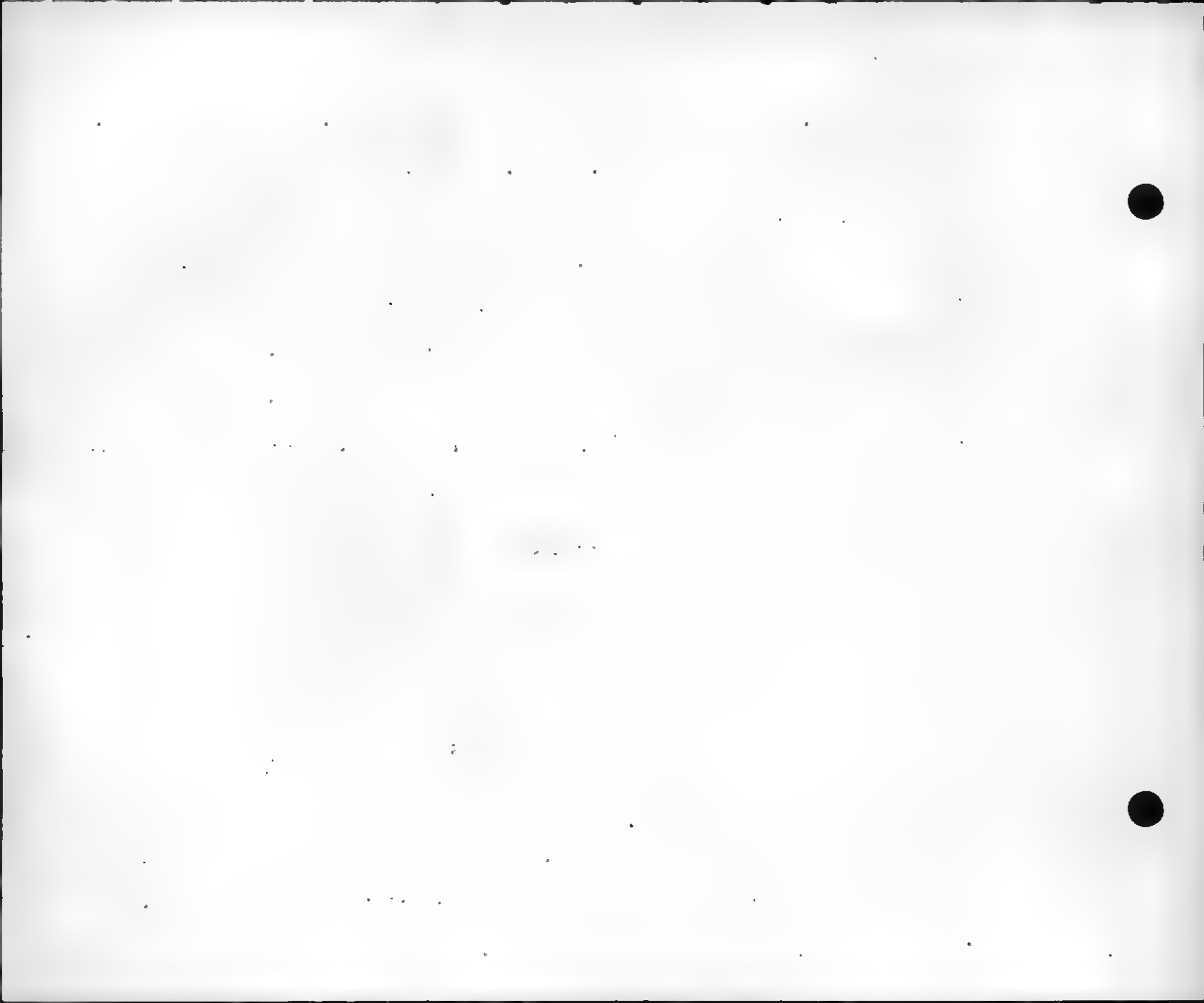
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
16073 CERTIFICATE OF DEATH 10069									
1. PLACE OF DEATH a. COUNTY Wash. b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Williamsport c. LENGTH OF STAY IN 1b 3Wks.2Days. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Williamsport Sanitarium					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Williamsport Rd2 d. STREET ADDRESS 106 Williams Circle e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Belle			First Belle Middle K. Last Keefer		4. DATE OF DEATH Month November Day 5 Year 1967				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-28-1887		9. AGE (In years last birthday) 80 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Hagerstown Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Kreps					14. MOTHER'S MAIDEN NAME Emma C. Bell				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)			16. SOCIAL SECURITY NO. 214-54-0363		17. INFORMANT Mr. Fred F. Keefer Williamsport Md. Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma - Pancreas DUE TO (b) Metastasis to Liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 10 WEEKS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/8 , 19 67 , to 11/3 , 19 67 , that (I) (we) last saw the deceased alive on 11/3 , 19 67 , and that death occurred at 12:30 PM , from the causes and on the date stated above.									
22a. SIGNATURE A. Mandell					ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/6/67		
22c. PHYSICIAN'S NAME (Type) A. MANDELL, MD					22d. ADDRESS 301 E. ANTIETAM ST.				
23a. BURIAL, CREMATION, or other disposition (Specify) Burial			23b. DATE THEREOF 11-8-67		23c. NAME OF CEMETERY OR CREMATORY Broadfording Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Md.		
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown Md. ADDRESS					25a. REC'D BY REGISTRAR NOV 8 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

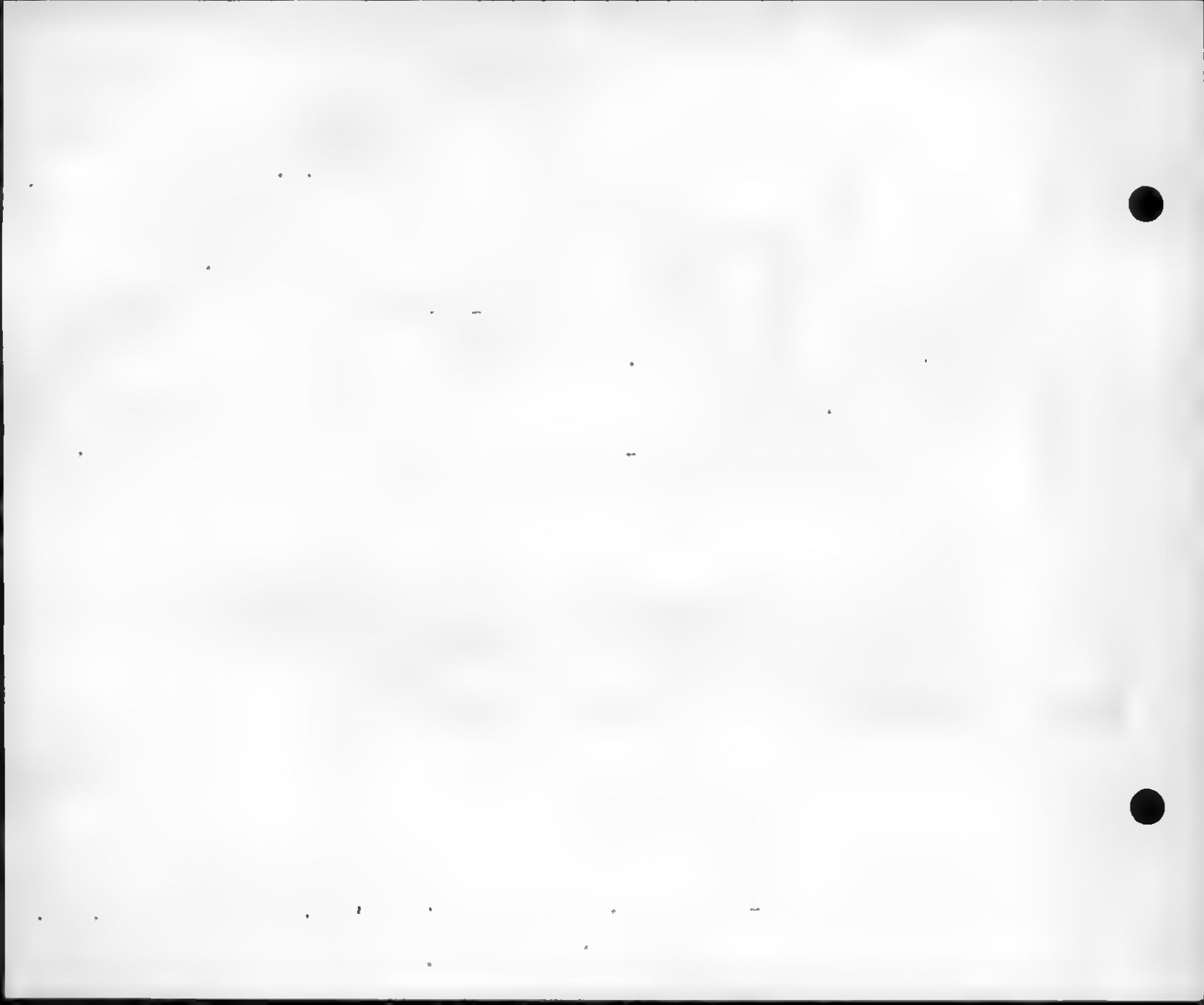
CERTIFICATE OF DEATH

16080

16070

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lantz P.O. d. STREET ADDRESS Foxville e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Raymond Kendall				4. DATE OF DEATH Month Day Year Nov. 26 1967									
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-30-1890		9. AGE (In years b. rthday) yrs 77		IF UNDER 1 YEAR Months Days Halvs Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Security Police				10b. KIND OF BUSINESS OR INDUSTRY Int. Harvester		11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY USA			
13. FATHER'S NAME Jacob D. Kendall						14. MOTHER'S MAIDEN NAME Esther Smith							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO 277-03-7306		17. INFORMANT Address Mrs. Haven Kendall Lantz, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 465X pulmonary embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 6 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of urinary bladder, carcinoma prostate, arteriosclerosis, heart disease												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (1) (this hospital) attended the deceased from Oct 15, 1967, to Nov 26, 1967, that (1) (we) last saw the deceased alive on Nov 26, 1967, and that death occurred at 11:59 AM, from causes and on the date stated above													
22a. SIGNATURE Joseph C. Creager MD						ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) JOSEPH C. CREAGER						22d. ADDRESS Hagerstown Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-29-67		23c. NAME OF CEMETERY OR CREMATORY Mt. Bethel Meth. Cem.				23d. LOCATION (City or Town) (County) (State) Nr. Foxville Fred. Co.					
24. FUNERAL DIRECTOR Raymond E. Creager						25a. REC'D BY REGISTRAR Thurmont, Md.		25b. REGISTRAR'S SIGNATURE Nov 30 1967					



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

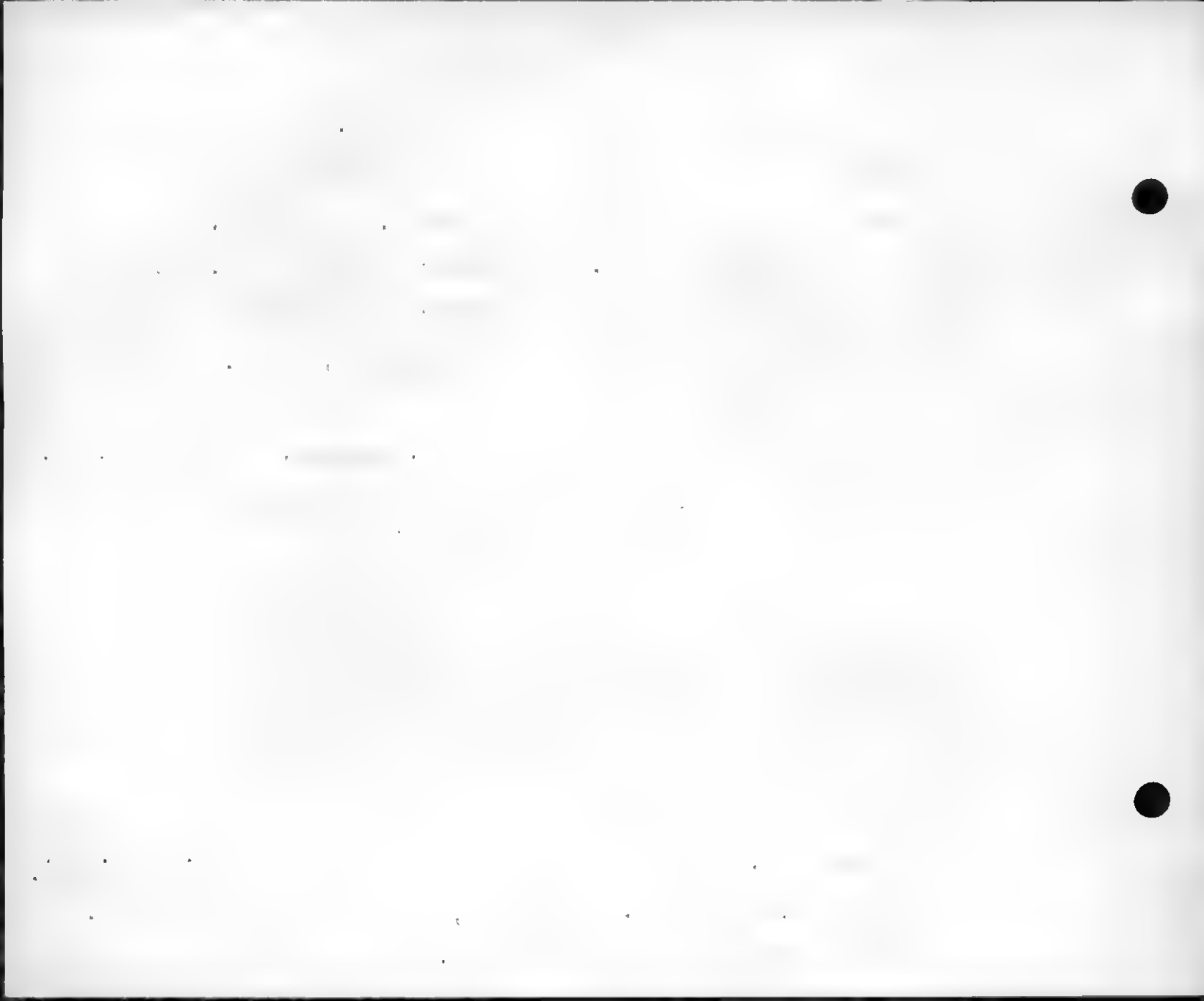
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Washington MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Penna. b COUNTY Franklin		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c LENGTH OF STAY IN 1b 17 days		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greencastle	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital			d STREET ADDRESS 340 S. Allison St.		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) First George Middle W. Last Kennedy			4 DATE OF DEATH Month Nov. Day 14 , Year 1967		
5 SEX male	6 COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2-12-87	9 AGE (in years last birthday) 80 yrs	F UNDER 1 YEAR Months Days Hours Mins IF UNDER 24 HRS
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) station master		10b KIND OF BUSINESS OR INDUSTRY railroad		11 BIRTHPLACE (State or foreign country) Harrisburg, Penna.	
13. FATHER'S NAME Luther Kennedy			14. MOTHER'S MAIDEN NAME Anna Collins		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WW-1		16 SOCIAL SECURITY NO 716-09-7103		17 INFORMANT Address Helen L. Kennedy, Greencastle, Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lobar Pneumonia Secondary to DUE TO (b) Fracture of Right Femur Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)					INTERVAL BETWEEN ONSET AND DEATH 3-5 days 17 days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Chronic Nephrosclerosis, Benign & Diabetic Mellitus & Arteriosclerotic Heart Disease					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Tripped over Rug - Fell to Floor of Home			
20c TIME OF INJURY Month Day Year Hour 1:20 p.m. 10/25/1967		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f (City or town) Greencastle	(County) Franklin (State) Pa.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Edward W. Ditto III		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 11-14-67	
EXAMINER'S NAME (Type) Edward W. Ditto III		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) burial		23b DATE THEREOF 11-16-67		23c NAME OF CEMETERY OR CREMATORY B. Harrisburg, Cemetery	
24 FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a REC'D BY REGISTRAR DATE NOV 16 1967		25b REGISTRAR'S SIGNATURE Charles Judge	
23d LOCATION (City or Town) (County) (State) Penbrook, Penna.					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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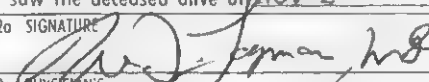

VR A15 (4)
25M 1/67

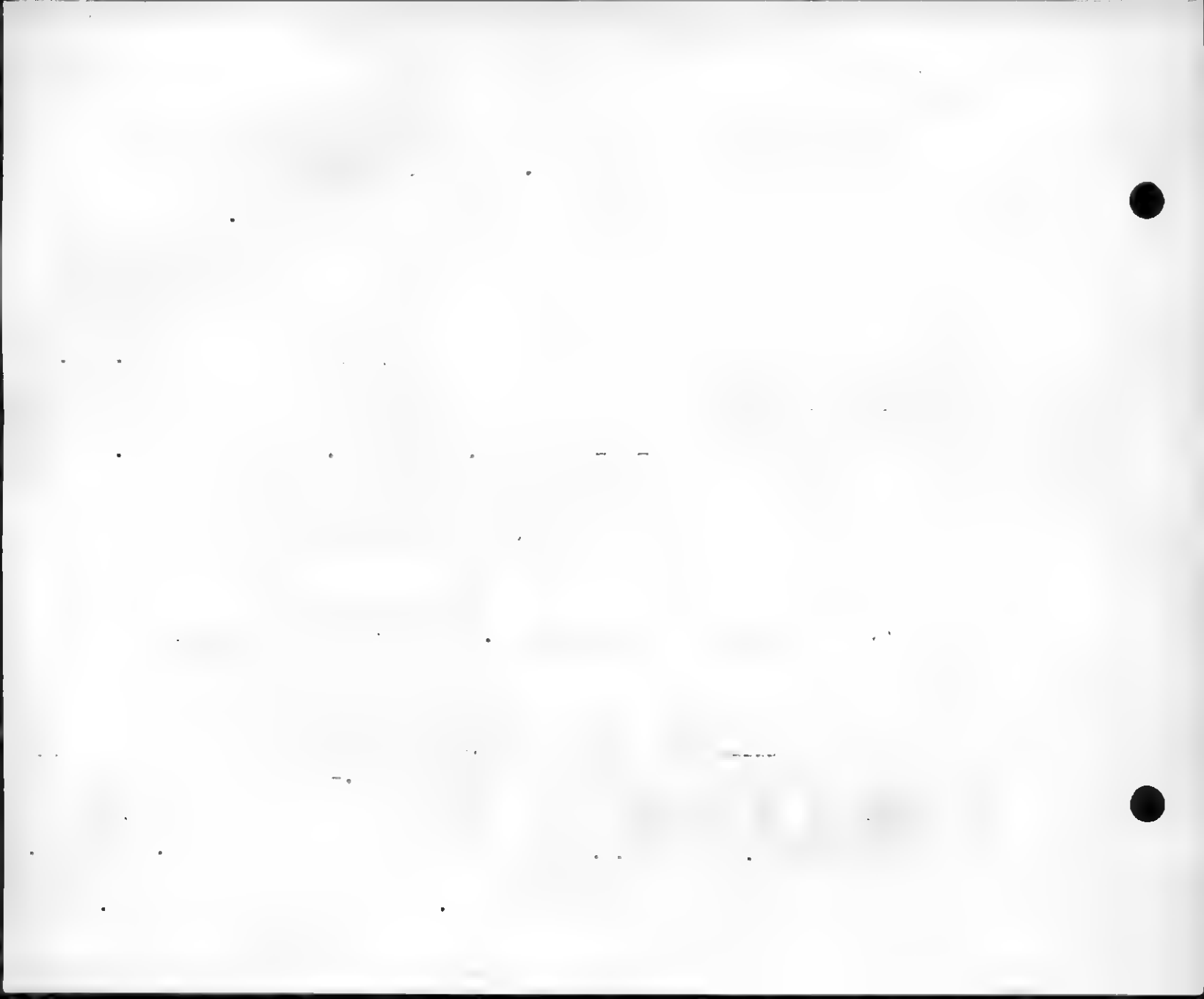
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16082

CERTIFICATE OF DEATH

16072

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 70 YRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. STREET ADDRESS 820 VIRGINIA AVE.	
3. NAME OF DECEASED (Type or print) First EDWARD Middle LAWRENCE Last KLINE		4. DATE OF DEATH Month NOVEMBER Day 3 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/29/1890
9. AGE (In years last birthday) 77 yrs		10. IF UNDER 1 YEAR Months 7 Days 7 Hours 7 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED BOILER MAKER		10b. KIND OF BUSINESS OR INDUSTRY RAIL ROAD	
11. BIRTHPLACE (County & State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SCOTT M. KLINE		14. MOTHER'S MAIDEN NAME CORA KEEFER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 717-07-9301	
17. INFORMANT HAGERSTOWN		18. MRS. MINNIE V. KLINE MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerotic and Hypertensive Cardiovascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5yrs 8 mn	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Pyelonephritis & Nephrosclerosis. Arteriosclerosis Obliterans		19. WAS A JTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 27 , 19 67 , to Nov 3 , 19 67 , that (I) (we) last saw the deceased alive on Nov 2 , 19 67 , and that death occurred at 7.-A.M. , from causes and on the date stated above			
22a. SIGNATURE 		22b. DATE SIGNED Nov 4, 1967	
22c. PHYSICIAN'S NAME (Type) William T. Layman, M.D.		22d. ADDRESS 100 Professional Arts Bldg. Hagerstown.	
23a. BURIAL, CREMATION REMOVED TO (Specify) BURIAL	23b. DATE THEREOF 11/6/67	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.
24. FUNERAL DIRECTOR W. T. Normant, Hagerstown, Md.		25a. REC'D BY REGISTRAR NOV 8 1967	
25b. REGISTRAR'S SIGNATURE 			



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15083

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

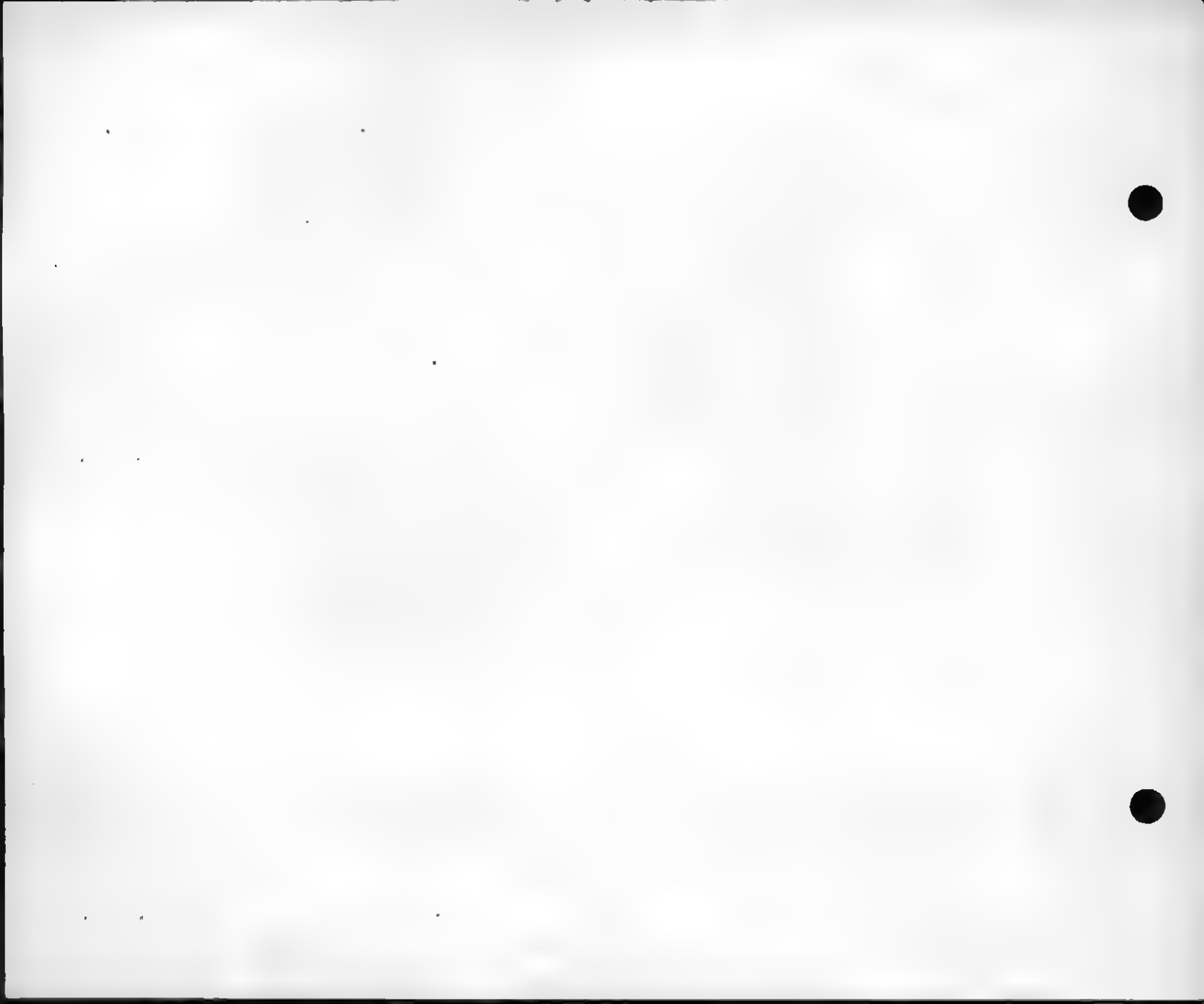
13073

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Wash.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 16 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital			d. STREET ADDRESS 875 Pine St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Frederick Middle Albert Last Lancaster			4. DATE OF DEATH Month November Day 29 Year 19 67		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-13-07	9. AGE (In years last birthday) 60 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) general work		10b. KIND OF BUSINESS OR INDUSTRY pest exterminators		11. BIRTHPLACE (County & State, or foreign country) Mt. Savage, Md.	
13. FATHER'S NAME Benjamin Lancaster			14. MOTHER'S MAIDEN NAME Jennie Shuckhart		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 214-05-9703	17. INFORMANT Emma Lancaster, Hagerstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Atherosclerosis DUE TO (c) Diabetes Mellitus					INTERVAL BETWEEN ONSET AND DEATH 2 hours Years 20 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 28 Nov, 1967 to 29 Nov, 1967 that (I) (we) last saw the deceased alive on 28 Nov 1967 , and that death occurred at 3:4 M, from causes and on the date stated above					
22a. SIGNATURE J. D. Wilson		MD ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 11/29/67	
22c. PHYSICIAN'S NAME (Type) J. D. WILSON		22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-1-67	23c. NAME OF CEMETERY OR CREMATORY Bedar Lawn Mem. Garden	23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.		
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE DEC 6 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16084

16074

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN TB 3 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 862 Frederick Street				d. STREET ADDRESS 862 Frederick Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last IRENE ELIZABETH LOWMAN				4. DATE OF DEATH Month Day Year November 29, 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 18 1912		9. AGE (In years lost birthday) yrs. 55	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Examiner		10b. KIND OF BUSINESS OR INDUSTRY Dorbee Mfg Co		11. BIRTHPLACE (County & State or foreign country) Md. Hagerstown Wash Co		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Gross				14. MOTHER'S MAIDEN NAME Susan Wilkes			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 112-24-5498		17. INFORMANT Address John H. Lowman Sr 862 Frederick St			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Hagerstown Md Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 hr	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis of Liver							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 18, 1967 to Nov 29, 1967 that (I) (we) last saw the deceased alive on Nov 29, 1967 and that death occurred at 8:45 AM , from causes and on the date stated above.							
22a. SIGNATURE J.H. Beachley				22b. DATE SIGNED Nov 30, 1967		22c. PHYSICIAN'S NAME (Type) J.H. Beachley	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/2/67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery Hagerstown Wash Co Md		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc				25a. REC'D BY REGISTRAR DEC 4 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

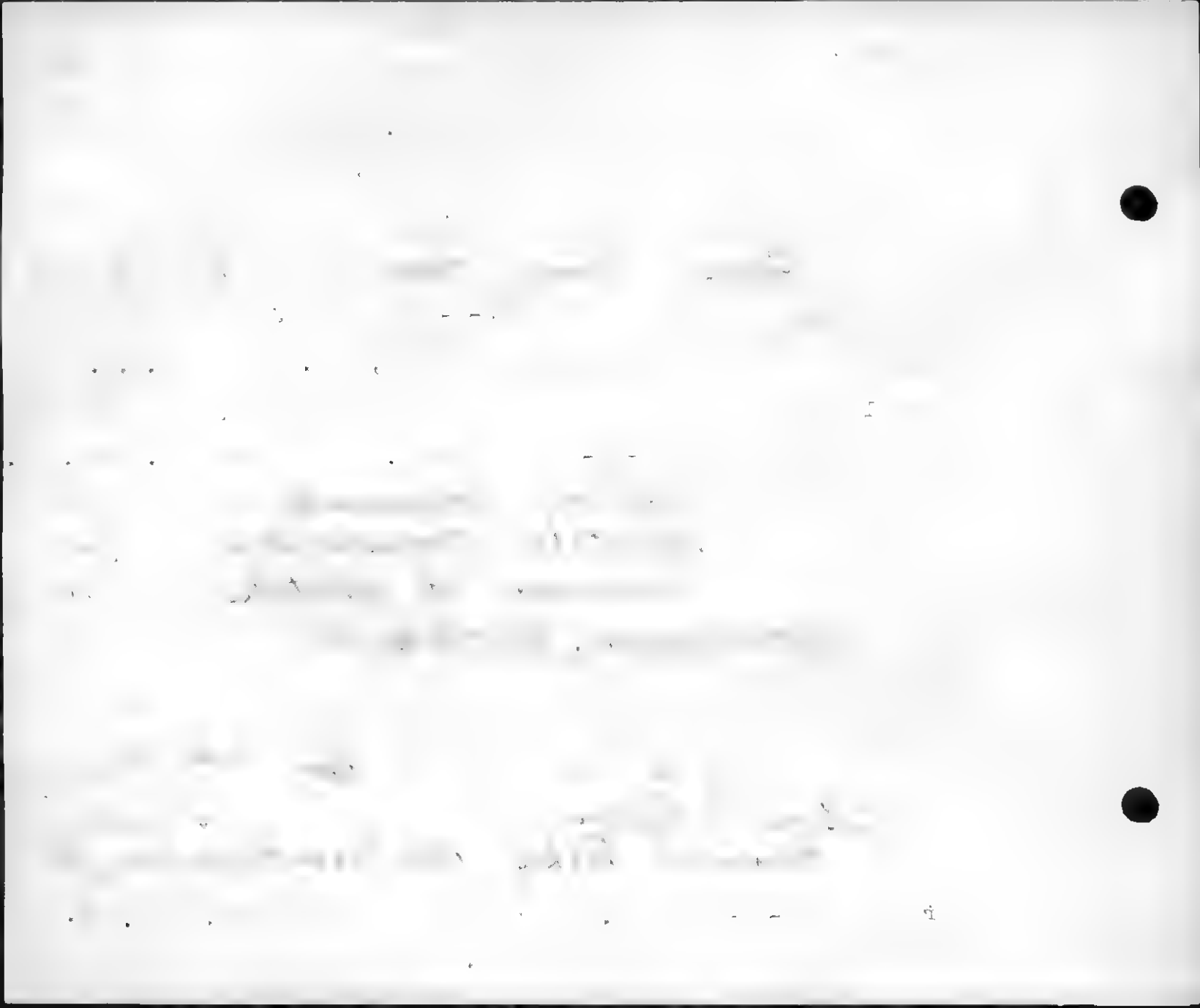
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10075

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Md. b COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL		d STREET ADDRESS Ridge Road	
3 NAME OF DECEASED (Type or print) First George Middle Thomas Last Magee		4 DATE OF DEATH Month 11 Day 25 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3-6-1884
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b KIND OF BUSINESS OR INDUSTRY Construction	9. AGE (In years last birthday) yrs. 83
11. BIRTHPLACE (County & State, or foreign country) Cairo, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Samuel Magee		14. MOTHER'S MAIDEN NAME Anna Marie Morris	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 332-03-5179	
17. INFORMANT Adlai S. Magee		Address Ridge Rd. Fred. Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia DUE TO (b) Metastatic carcinomatosis DUE TO (c) Carcinoma of prostate Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH 3d 3 mon 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Nephrosclerosis, bronchiectasis		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11-14 , 19 67 , to 11-25 , 19 67 , that (I) (we) last saw the deceased alive on 11-25 , 19 67 , and that death occurred at 5:45 PM , from causes and on the date stated above			
22a. SIGNATURE Edwin G. Riky M.D.		22b. DATE SIGNED 11-26-67	
22c. PHYSICIAN'S NAME (Type) Edwin G. Riky		22d. ADDRESS 1500 Penna, Hagerstown, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-28-67	23c. NAME OF CEMETERY OR CREMATORY St. John's Cem	23d. LOCATION (City or Town) (County) (State) Frederick, Fred. Md.
24. FUNERAL DIRECTOR Salamone Funeral Home Frederick, Md.		25a. REC'D BY REGISTRAR DATE NOV 28 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge

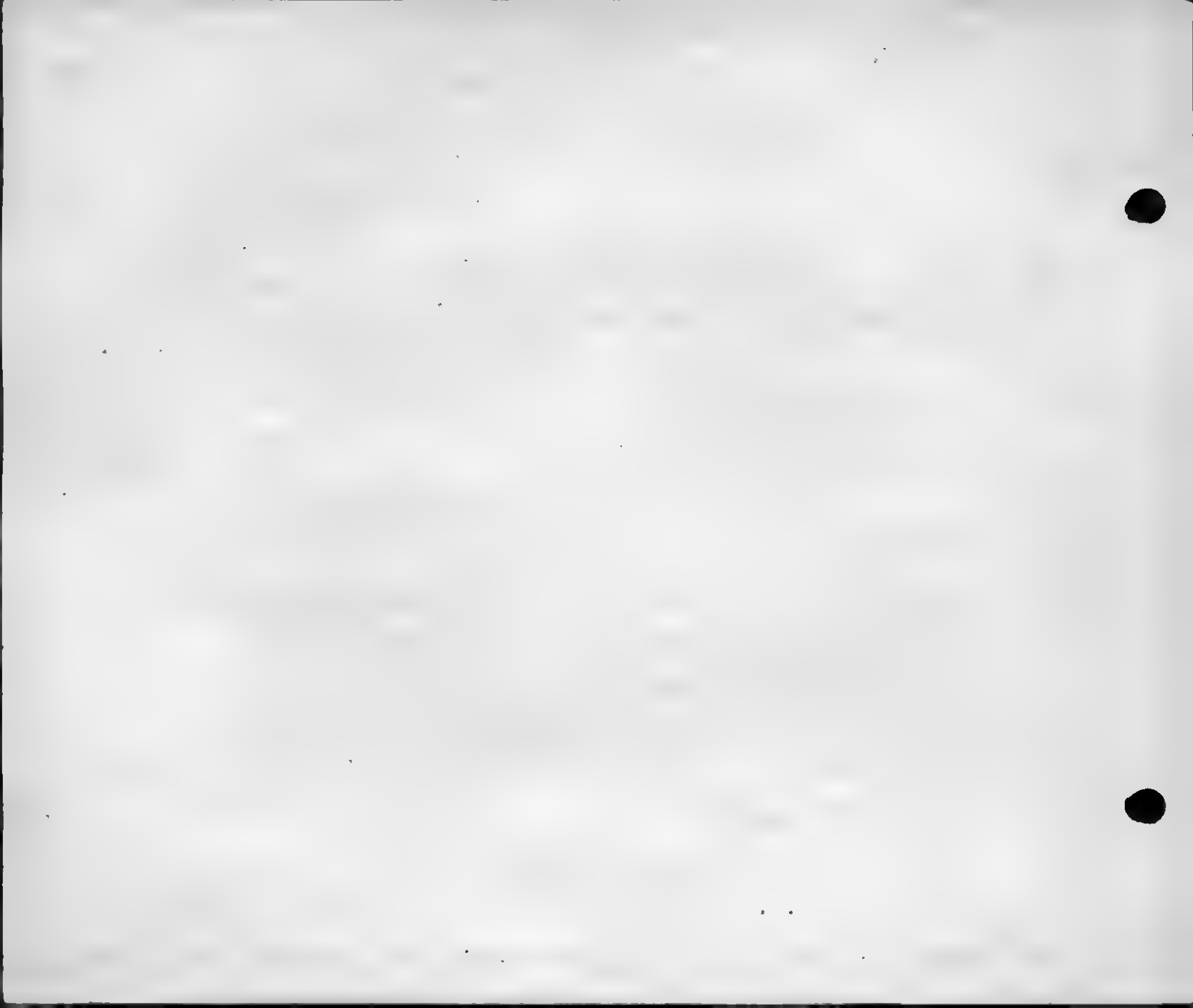
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>1</div> <div>6088</div> <div>1967</div>									
<div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div>									
1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL 2 c. LENGTH OF STAY IN 1b 29 YRS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HOME					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL 2 d. STREET ADDRESS HANCOCK MARYLAND e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First EVELYN Middle LAVINA Last MILLER					4. DATE OF DEATH Month 11 Day 4 Year 19 67				
5. SEX F					6. COLOR OR RACE W				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH JAN. 31. 1910				
9. AGE (In years last birthday) 57 yrs.					IF UNDER 1 YEAR Months 57 Days 4		IF UNDER 24 HRS. Hours 19 Min. 67		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (County & State, or foreign country) ALLEGANY COUNTY					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME CLEVELAND D MILLER					14. MOTHER'S MAIDEN NAME RUTH G BRANT				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. NONE				
17. INFORMANT MRS RUTH G MILLER					Address RURAL 2 HANCOCK MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Branchial pneumonia DUE TO Pulmonary Edema Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Diabetes (c) Diabetes									INTERVAL BETWEEN ONSET AND DEATH 3 HRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Oct 12, 1967 to Nov 4, 1967 , that (I) (we) last saw the deceased alive on 11/4, 1967 , and that death occurred at 11:55 , from the causes and on the date stated above.									
22a. SIGNATURE L. M. Shaffer					22b. DATE SIGNED 11/7/67		22c. PHYSICIAN'S NAME (Type) L. M. SHAFFER M.D.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					23b. DATE THEREOF 11.7.1967		23c. NAME OF CEMETERY OR CREMATORY PRESBYTERIAN		23d. LOCATION (City, town or county) (State) HANCOCK WASHINGTON MD
24. FUNERAL DIRECTOR'S SIGNATURE Howard J. Stone					ADDRESS Hancock Md.		25a. REC'D BY REGISTRAR NOV 9 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>28 Harman Ave.</u>		d. STREET ADDRESS <u>28 Harman Ave.</u>	
3 NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Charlotte</u> Last <u>Miller</u>		4 DATE OF DEATH Month <u>November</u> Day <u>8</u> Year <u>19 67</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Dec. 30, 1910</u>
9. AGE (in years last birthday) yrs <u>56</u>		F UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles O. Stoner Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Anna L. Flickinger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Samuel L. Miller</u>		Address <u>28 Harman Ave. Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ATHEROSCLEROSIS</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2</u> <u>years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6 Nov</u> , 19 <u>67</u> , to <u>8 Nov</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6 Nov</u> , 19 <u>67</u> , and that death occurred at <u>3 P.</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>J. D. Wilson</u>		22b. DATE SIGNED <u>11/10/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. D. WILSON</u>		22d. ADDRESS <u>580 Northern Ave HAGERSTOWN</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/12/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>
24. FUNERAL DIRECTOR <u>Wm. G. Nowak</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 13 1967</u>	
Address <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

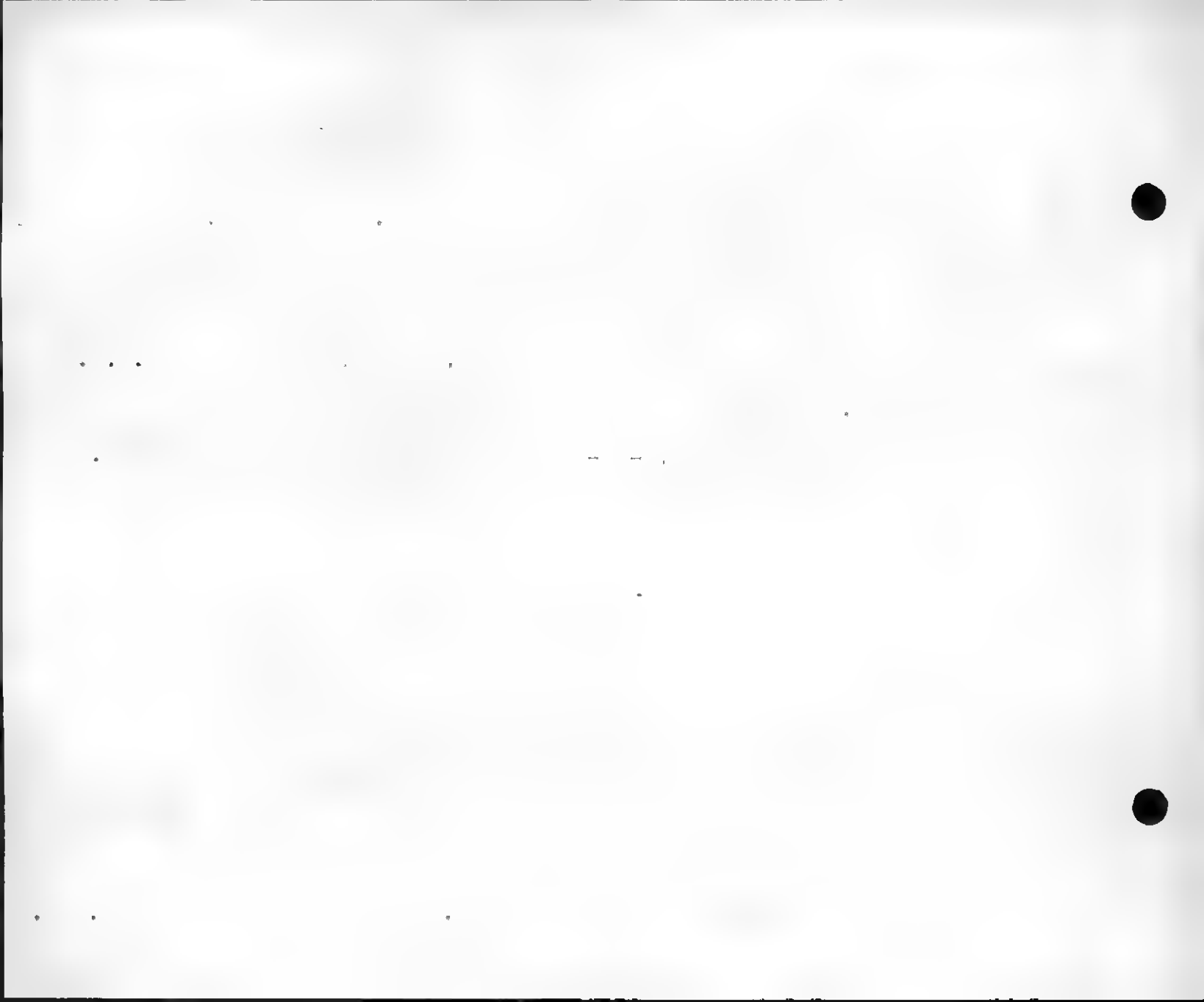
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CERTIFICATE OF DEATH

13078

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY in it LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS 302 N. POTOMAC ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROBERT Middle EDWIN Last MILLER		4. DATE OF DEATH Month NOVEMBER Day 10 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/7/1907
9. AGE (In years last birthday) 60 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TITLE SEARCHER		10b. KIND OF BUSINESS OR INDUSTRY ELECTRIC POWER CO. MARYLAND	
11. BIRTHPLACE (County & State or foreign country) CO. MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MARX W. MILLER		14. MOTHER'S MAIDEN NAME LOUISA LUSHBAUGH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 214-10-4628	
17. INFORMANT MR. HUBERT E. MILLER		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Bladder DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			INTERVAL BETWEEN ONSET AND DEATH 10 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on Nov. 10 19 67 , and that death occurred at 10 M, from causes and on the date stated above.			
22a. SIGNATURE <i>Lloyd A. Hoffman</i> M.D.		22b. DATE SIGNED 11/11/67	
22c. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman		22d. ADDRESS 214 N. Potomac St.	
23a. BURIAL, CREMATION, REMOVAL BURIAL	23b. DATE THEREOF 11/13/67	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.
24. FUNERAL DIRECTOR <i>W. J. Norment, Hagerstown, Md.</i>		25a. REGD. BY REGISTRAR NOV 15 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



**FOR STATE
HEALTH DEPT**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, removal, and in any event within 72 hours after death.

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6M 1/67

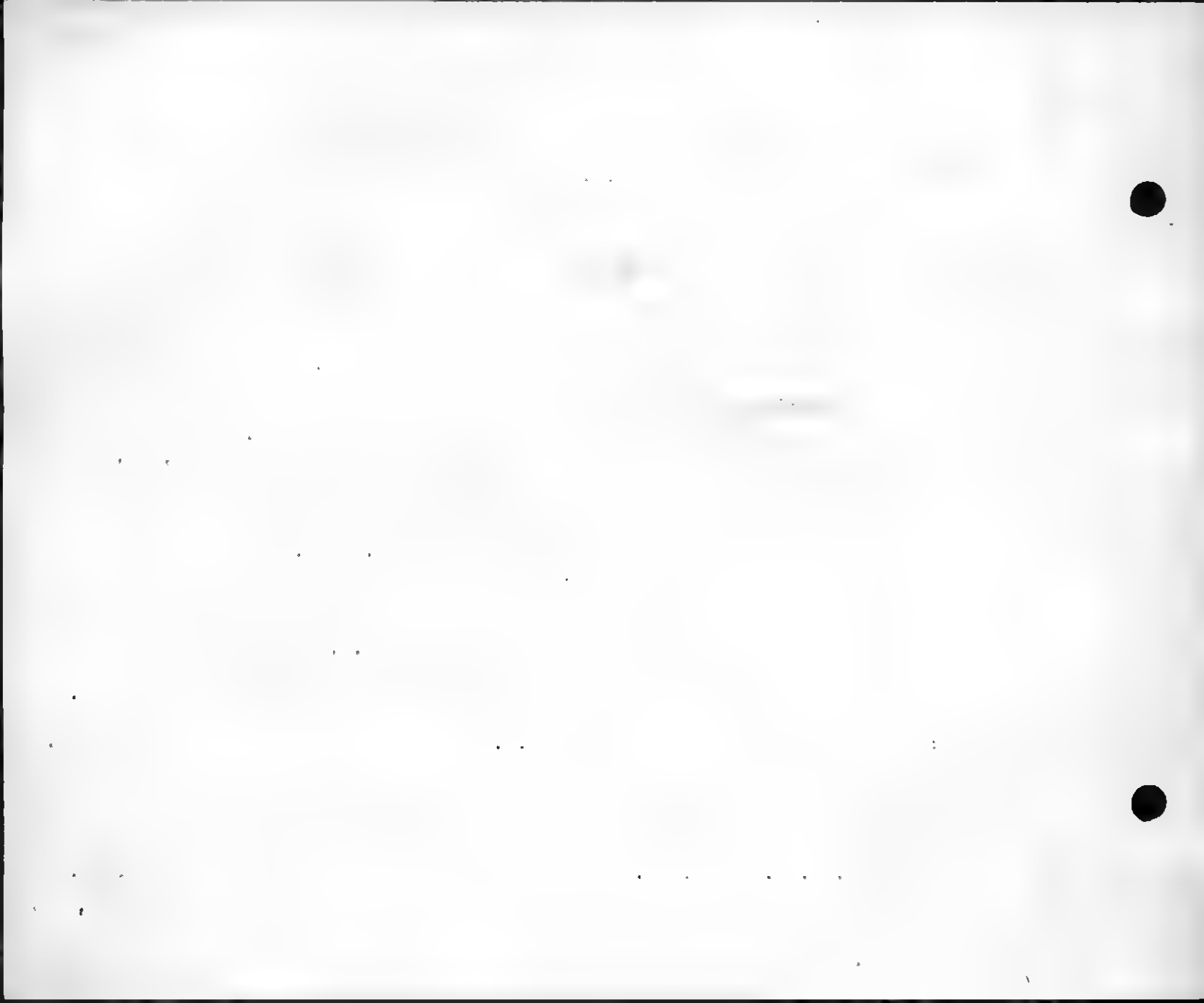
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15088

13279

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Car Accident Interstate 37 Wash. Co. Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gaither</u> Middle <u>Irvin</u> Last <u>Mills</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>October 4, 1907</u>
9. AGE (in years last birthday) <u>59</u>		10. FINDER 1 YEAR Months <u>0</u> Days <u>28</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft</u>	
11. BIRTHPLACE (State or foreign country) <u>Williamsport, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Mills</u>		14. MOTHER'S MAIDEN NAME <u>BESSIE Robinson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-10-1200</u>	
17. INFORMANT <u>Mr. Hubert Hill</u>		17. ADDRESS <u>102 E. Church St. Williamsport, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Basal Fracture Of Skull</u> <u>9164</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Multiple Fractures Of Ribs Rt. & Lt. Side</u> DUE TO (c) <u>(Crushed Chest)</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Passenger in car north lane U.S. 81 struck by car crossing over from south lane near Halfway intersection.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) <u>car crossing over from south lane near Halfway intersection.</u>	
20c. TIME OF INJURY Month, Day, Year <u>7:35 p.m. 11-3-1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at home <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>U.S. 81</u>		20f. (City or town) (County) (State) <u>Hagerstown, Washington, Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Dr. E. W. Ditto, Jr.</u>		22. DATE SIGNED <u>11-4-67</u>	
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		Address (Street, city, town, or county) <u>Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REINTERMENT (Specify) <u>buried</u>	23b. DATE THEREOF <u>Nov. 7-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Divorvier Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Williamsport Wash. Co. Md.</u>
24. FUNERAL DIRECTOR <u>Albert L. Leaf Williamsport Maryland</u>		25a. REC'D BY REGISTRAR <u>NOV 7 1967</u>	
ADDRESS <u>Williamsport Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

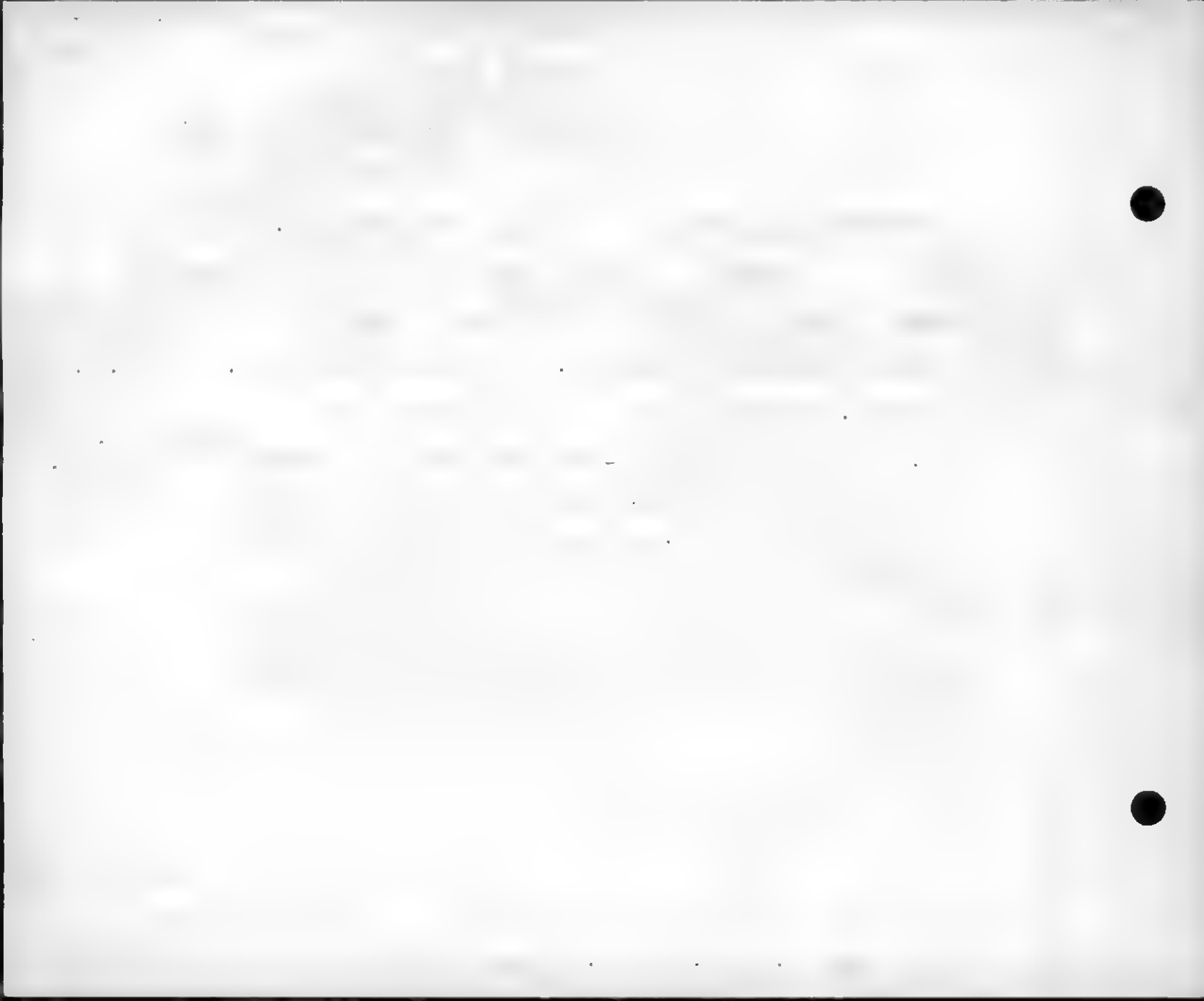
16080

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 45 Yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 299 Summit Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Blanche Anna Mumma				4. DATE OF DEATH Month Day Year November 17, 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6, 1908		9. AGE (n years last birthday) 59 yrs	10. IF UNDER 1 YEAR Months Days Hours Min. 7 11	11. IF UNDER 24 HRS. Hours Min. 11
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Operator		10b. KIND OF BUSINESS OR INDUSTRY Railroad Co.		11. BIRTHPLACE (County & State or foreign country) Rural Keedysville, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles T. Mumma				14. MOTHER'S MAIDEN NAME Isabell Wolf			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 705-10-6872		17. INFORMANT Miss Catherine I. Mumma, 299 Summit Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertension Coronary Occlusion 7201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension Heart Disease DUE TO (c) Sudden INTERVAL BETWEEN ONSET AND DEATH 14 months						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 66 11/17 67	
21. I certify that (I) (this hospital) attended the deceased from 8/11 , 19 66 to 11/17 , 19 67 , that (I) (we) last saw the deceased alive on 10/20 , 19 67 , and that death occurred at 9:00 PM , from causes and on the date stated above.							
22a. SIGNATURE Donald E. Martin				22b. DATE SIGNED 11/20/67		22c. PHYSICIAN'S NAME (Type) Donald E. Martin, M.D.	
22d. ADDRESS 418 N. Potomac St., Hagerstown, Md. 21740							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-20-67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.				25a. REC'D BY REGISTRAR NOV 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16091

16081

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file them in the funeral director's file. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS 207 AVON ROAD			
3. NAME OF DECEASED (Type or print) First ROY Middle EDWIN Last MYERS				4. DATE OF DEATH Month NOVEMBER Day 8 Year 1967			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 26, 1888		9. AGE (in years last birthday) 79	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. FURNITURE FINISHER. FURNITURE MFG.				10b. KIND OF BUSINESS OR INDUSTRY HAGERSTOWN, MD.		11. BIRTHPLACE (County & State, or foreign country) U.S.A.	
13. FATHER'S NAME EDWIN H. MYERS				14. MOTHER'S MAIDEN NAME MARY ALEXANDER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO ***				16. SOCIAL SECURITY NO 214-09-09864		17. INFORMANT MRS. MILDRED DOWLER, 331 RIDGE AVE. HAGERSTOWN, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardiac failure - asystole 4300 DUE TO (b) complete heart block Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) arteriosclerotic heart disease INTERVAL BETWEEN ONSET AND DEATH 2 days						19. WAS A TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 0				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) this physician attended the deceased from 11/8/67 to death , 19 67 , that (I) we last saw the deceased alive on 11/8/67 , and that death occurred at 11 M, from causes and on the date stated above.							
22a. SIGNATURE John C. Stauffer				22b. DATE SIGNED 11/10/67		22c. PHYSICIAN'S NAME (Type) JOHN C. STAUFFER, M.D.	
22d. ADDRESS 145 S. PROSPECT ST. HAGERSTOWN, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/11/67		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. CO. MD.	
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MD.				25. FILED BY REGISTRAR NOV 15 1967			
26. REGISTRAR'S SIGNATURE Charles Judge							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16092

CERTIFICATE OF DEATH

1967

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>41 yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>113 Bryan Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>Beatrice</u> Last <u>Nicewarner</u>				4. DATE OF DEATH Month <u>November</u> Day <u>8</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 16, 1908</u>	
9. AGE (In years last birthday) <u>58</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Covington, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office work</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Montgomery Ward</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Covington, Va.</u>	
13. FATHER'S NAME <u>Walton Fitzgerald</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Shoemaker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>217-12-1979</u>		17. INFORMANT <u>Mr. D.C. Nicewarner</u> Address <u>113 Bryan Pl. Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 35 yr DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerotic Vascular Disease</u> DUE TO (c) <u>Hypertensive Vascular Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>18 days</u> <u>8 mo.</u> <u>7 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 5, 1967</u> to <u>Nov 8, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov 5, 1967</u> , and that death occurred at <u>3:50 P.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Lloyd A. Hoffman</u> M.D.				22b. DATE SIGNED <u>11-9-67</u>		22c. PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffman</u>	
22d. ADDRESS <u>214 N. Potomac St. - Hagerstown, Md.</u>				22e. REC'D BY REGISTRAR <u> </u>			
22f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				22g. DATE <u>NOV 13 1967</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/11/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. C. Hoffman</u> <u>Rest Haven Funeral Chapel</u>				25. ADDRESS <u>Hagerstown, Md.</u>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

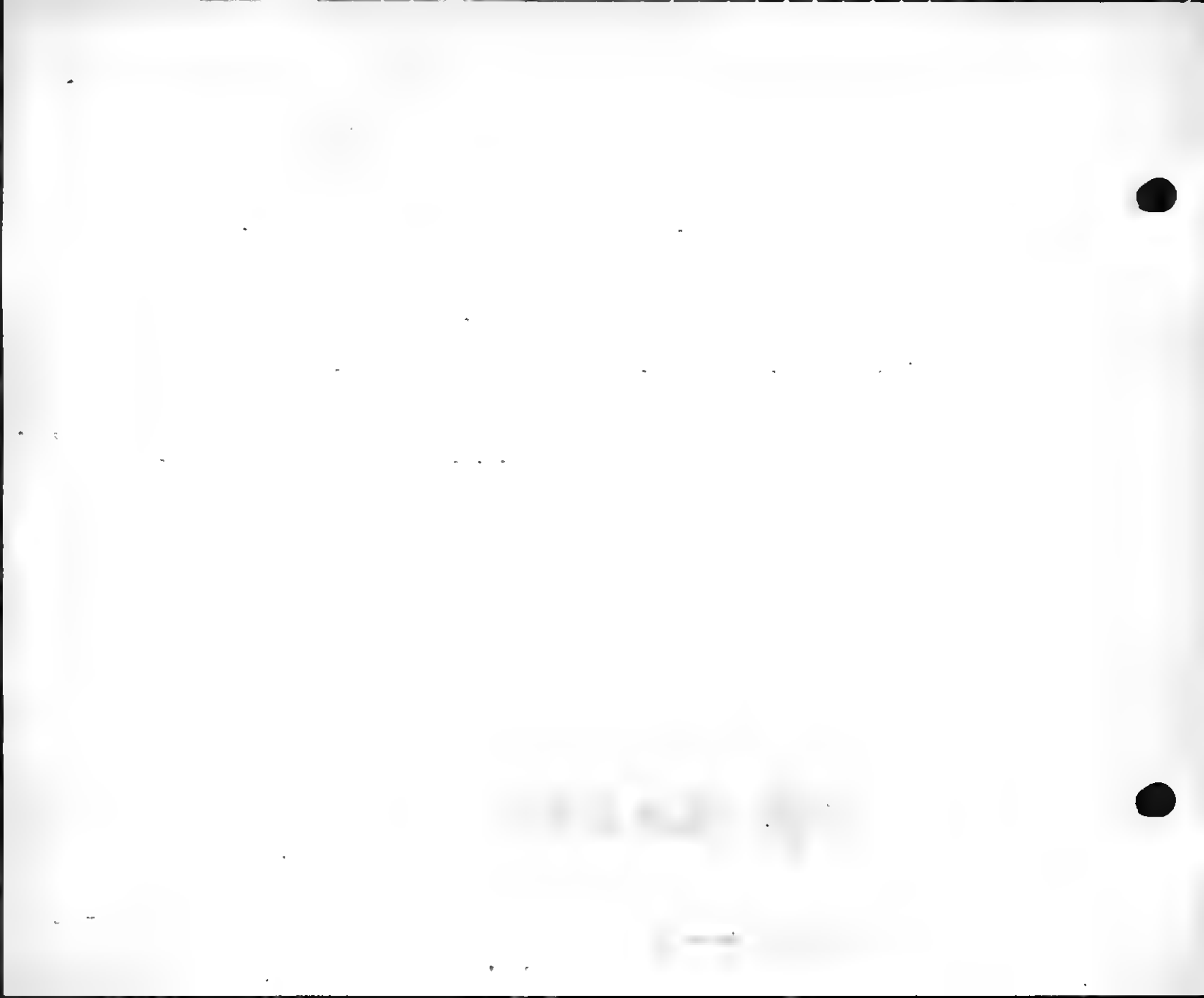
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AISNE
6M 1/1/67

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <u>Washington</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Washington</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mangansville</u>		c LENGTH OF STAY IN 1b <u>Life</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>446 Weaver Ave.</u>		d STREET ADDRESS <u>446 Weaver Ave.</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Clarence Earl Nonemaker</u>		4 DATE OF DEATH Month Day Year <u>November 8 19 67</u>	
5. SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Dec. 16, 1905</u>
9 AGE (In years last birthday) yrs <u>61</u>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Track man, Chaffee.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penna. Railroad</u>	
11 BIRTHPLACE (State or foreign country) <u>Carlisle, Pa.</u>		12 C.T. ZEN OF WHAT COUNTRY <u>USA</u>	
13 FATHER'S NAME <u>Lewis Nonemaker</u>		14 MOTHER'S MAIDEN NAME <u>Minnie Bell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>214-09-4080</u>	
17 INFORMANT <u>Mrs. C.E. Nonemaker</u>		Address <u>446 Weaver Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary occlusion</u> DUE TO (b) <u>Atherosclerotic cardiovascular disease</u> DUE TO (c) <u>Severe emphysema</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Yrs.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe emphysema</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Howard N. Weeks</u> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>580 Northern Ave., Hagerstown, Md.</u>	
22. DATE SIGNED <u>11/10/67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/11/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>
24. FUNERAL DIRECTOR <u>Wm. G. Nonemaker</u> <u>Rest Haven Funeral Chapel</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 13 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

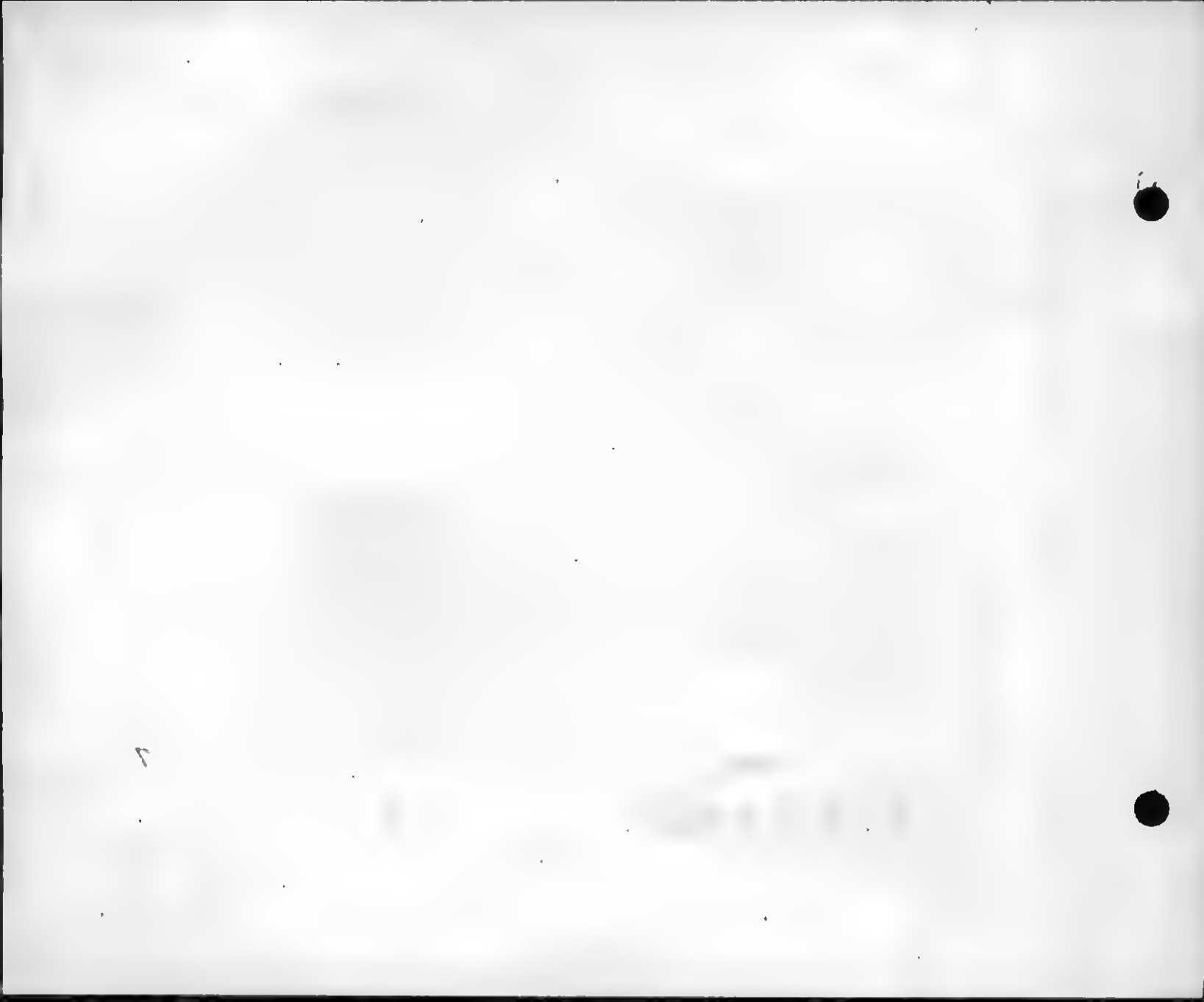
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CERTIFICATE OF DEATH

11784

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clearspring			c. LENGTH OF STAY IN 1b 30 yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clearspring 21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) S. Martin Street				d. STREET ADDRESS S. Martin Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Anna Middle Catherine Last Orcutt				4. DATE OF DEATH Month Nov. Day 7 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 27 1903		9. AGE (In years last birthday) yrs 63	10. IF UNDER 1 YEAR Months 11 Days 18 Hours 15 Min 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CR		10b. KIND OF BUSINESS OR INDUSTRY Ironing Home		11. BIRTHPLACE (County & State, or foreign country) Franklin Co. Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bruce Alfred Provard				14. MOTHER'S MAIDEN NAME Lillie V. Mummert			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 217-05-0813		17. INFORMANT Paul E. Orcutt 17D EL-Address 21v Washington D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary artery occlusion, with myocardial infarction 42 / DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c) Diabetes Mellitus						INTERVAL BETWEEN ONSET AND DEATH ?? ??	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from May 13 , 1966, to Nov. 7 , 1967, that (I) (the hospital) last saw the deceased alive on November 1 , 1967, and that death occurred at 8:15 AM from causes and on the date stated above.							
22a. SIGNATURE 				22b. DATE SIGNED Nov. 8, 1967		22c. PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.	
22d. ADDRESS Clear Spring, Maryland 21722				22e. ADDRESS Clear Spring, Maryland 21722			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF Nov. 10-67		23c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery		23d. LOCATION (City or town) (County) (State) Near Clearspring Wash. D.C.	
24. FUNERAL DIRECTOR Albert I. Leaf Williesport Maryland				25a. REC'D BY REGISTRAR NOV 10 1967		25b. REGISTRAR'S SIGNATURE 	

VR A15 (4)
25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16095

16085

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 927 days.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Herman Middle Pickett Last Pickett		4. DATE OF DEATH Month Nov. Day 16 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23, 1894
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min 1	11. IF UNDER 24 HRS Months 1 Days 1 Hours 1 Min 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer - retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Montgomery County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles F. Pickett		14. MOTHER'S MAIDEN NAME Ann Duvall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes 1941-1945		16. SOCIAL SECURITY NO. 013-24-7079	
17. INFORMANT Address R.D. 2 Mrs. Mary E. Pickett Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia DUE TO (b) Cerebral vascular accident DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 days 2 yrs 5 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 3, 1965 to Nov. 16, 1967 , that (I) (we) last saw the deceased alive on Nov. 16, 1967 , and that death occurred at 5:35 p.m. from causes and on the date stated above			
22a. SIGNATURE Edwin G. Riley		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Edwin G. Riley		22d. ADDRESS Western Md. State Hospital Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 11/11/1967	23c. NAME OF CEMETERY OR CREMATORY Northwood Memorial	23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.
24. FUNERAL DIRECTOR G. M. Waltz Box 241 Sykesville, Md.		25a. REC'D BY REGISTRAR DATE NOV 21 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16096

CERTIFICATE OF DEATH

10 86

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 7b <u>23 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick,</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>520 Pearl Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jeffrey</u> Middle <u>Allen</u> Last <u>Poole</u>				4. DATE OF DEATH Month <u>November</u> Day <u>21</u> , Year <u>19 87</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 24, 1965</u>		9. AGE (In years last birthday) <u>2</u> yrs	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS Hours _____ Min _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Frederick, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Donnie Lee Poole</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Ann Mercer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT Address <u>Mr. Donnie L. Poole 520 Pearl St. Fred. Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO (b) <u>Increased intracranial pressure</u> DUE TO (c) <u>Hydrocephalus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u> <u>4 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 31, 1967</u> , to <u>Nov. 21, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov. 21, 1967</u> , and that death occurred at <u>11:30 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>A.F. Abdullah</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>11-21-1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>A.F. Abdullah</u>				22d. ADDRESS <u>132 N. Potomac, Hagerstown Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-24-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Frederick, Maryland</u>	
24. FUNERAL DIRECTOR <u>Robert E. Bailey & Son</u>				ADDRESS <u>Frederick, Maryland</u>		25a. REC'D BY REGISTRAR <u>NOV 27 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

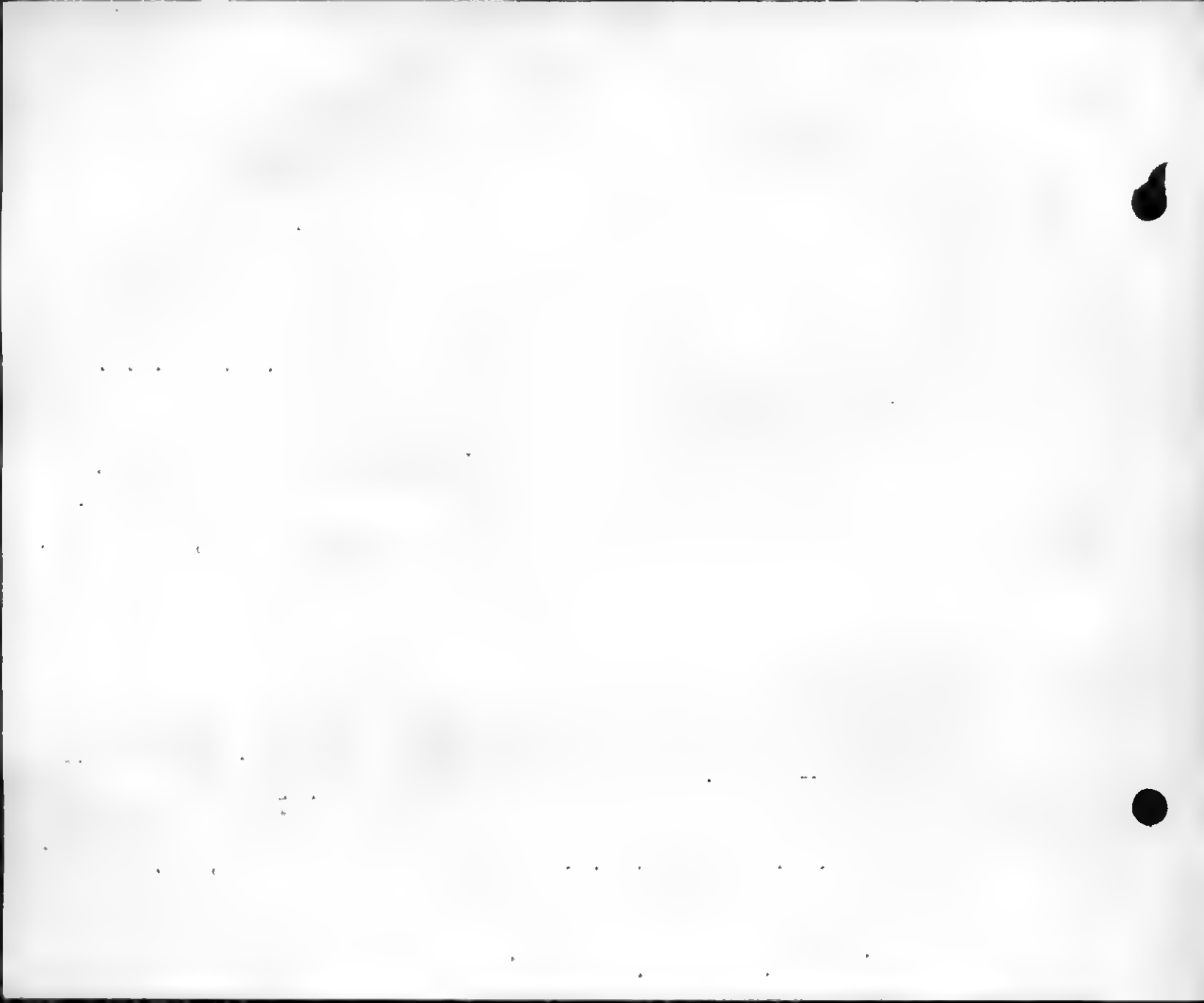
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Martin Monor Nursing Home		d. STREET ADDRESS 17 East Ave.	
3 NAME OF DECEASED (Type or print) First Viola Middle Brooke Last Reeves		4 DATE OF DEATH Month November Day 14 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH April 19, 1874
9 AGE (n years last birthday) yrs 93		10 UNDER 1 YEAR Months Days Hours Min. 11 UNDER 24 HRS.	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11 BIRTHPLACE (County & State, or foreign country) Shepherdstown, W. Va.		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Alexander Shaner		14 MOTHER'S MAIDEN NAME Georganna Swann	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16 SOCIAL SECURITY NO 13-48-3617	
17 INFORMANT Mrs. Gertrude Maisack		Address 56 Broadway Ave, Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Hypertensive cardiovascular disease, 10-15 yr. DUE TO (c) arteriosclerotic		INTERVAL BETWEEN ONSET AND DEATH 43 hr.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 19 , 19 67 , to Nov. 14 , 19 67 , that (I) (we) last saw the deceased alive on Nov. 12 , 19 67 , and that death occurred at 6:25 a.m. M. from causes and on the date stated above.			
22a SIGNATURE <i>B. B. Kneisley</i>		22b DATE SIGNED 11/15/67	
22c PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.		22d ADDRESS 148 West Washington St. Hagerstown, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 11/16/67	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d LOCATION (City or Town) (County) (State) Hagerstown, Maryland
24 FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc.		25a REC'D BY REGISTRAR NOV 17 1967	
ADDRESS Hagerstown, Maryland.		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



16098

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

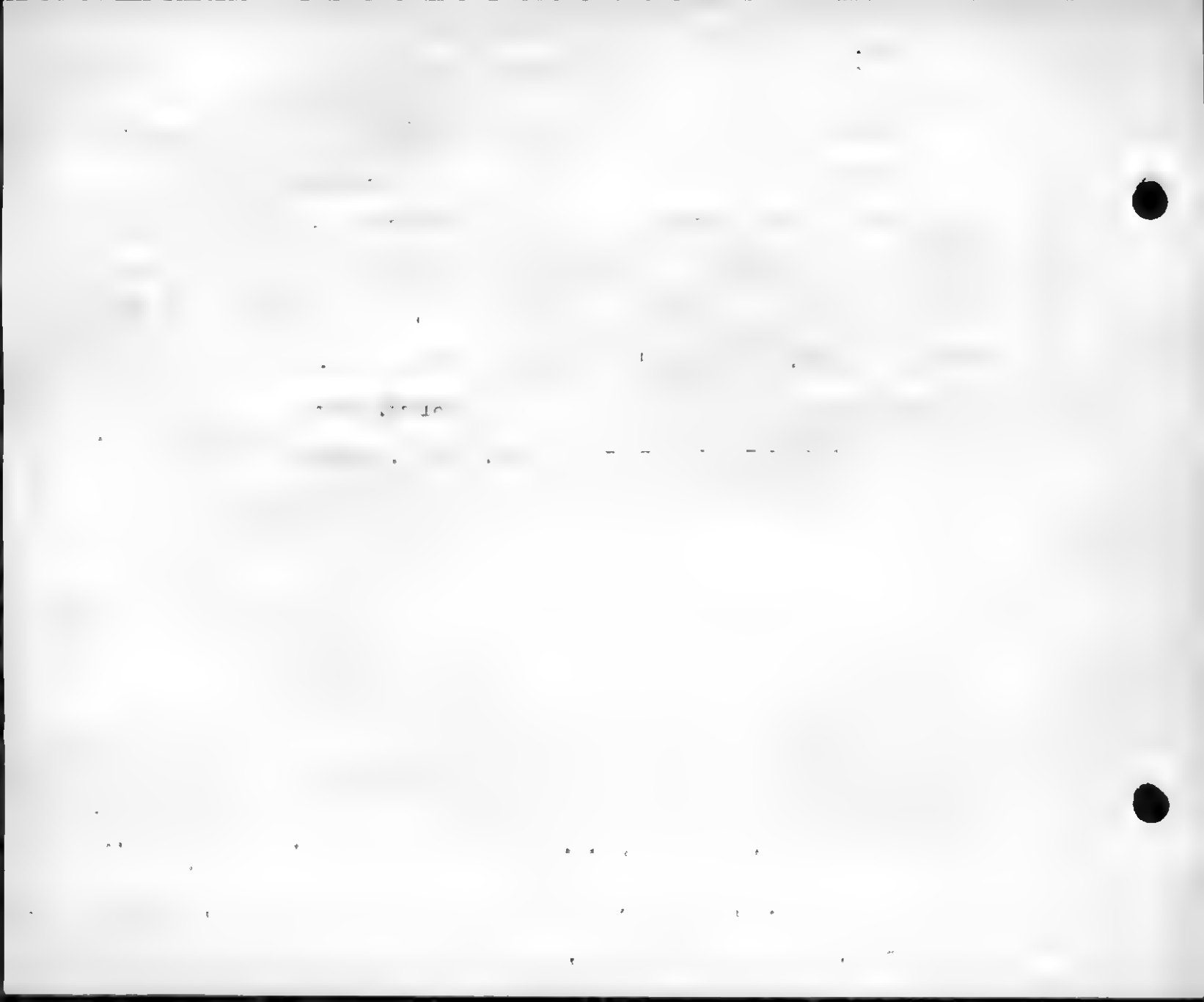
CERTIFICATE OF DEATH

16088

1 PLACE OF DEATH a. COUNTY Washington MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o STATE Maryland b COUNTY Washington	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c LENGTH OF STAY IN 1b 3 weeks	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e STREET ADDRESS Greencastle Pike RFD #1	
3 NAME OF DECEASED (Type or print) First CHARLES Middle EDWARD Last RICKARD		4. DATE OF DEATH Month Nov. Day 20 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 30, 1887
9 AGE (In years lost birthday) 80 yrs		10 IF UNDER 1 YEAR Months 4 Days 20 Hours Min.	11 BIRTHPLACE (County & State, or foreign country). Washington Co. Maryland
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer Dye Dept.		10b KIND OF BUSINESS OR INDUSTRY Byron's Tannery	12 CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Frank Rickard		14. MOTHER'S MAIDEN NAME Mollie Palmer	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 216-03-2085	
17 INFORMANT Mrs. Rosa R. Rickard		Williamsport, Md. RFD# 1	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4200 Congestive Heart Failure DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 2 months 6-7 years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2-5-1964 , to 11-20, 1967 , that (I) (we) last saw the deceased alive on 11-20-1967 , and that death occurred at 730 AM , from causes and on the date stated above.			
22a SIGNATURE John H. Hornbaker, M.D.		22b DATE SIGNED 11:20:67	22c PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.
22d ADDRESS 154 W. Washington St., Hagerstown, Md. 21740		22e REC'D BY REGISTRAR NOV 22 1967	
23a BURIAL, CREMATION, or other disposition (Specify) Burial	23b DATE THEREOF Nov. 23, 1967	23c NAME OF CEMETERY OR CREMATORY Broadfording Cemetery	23d LOCATION (City or Town) (County) (State) Broadfording, Maryland Wash. Co.
24. FUNERAL DIRECTOR Albert L. Leaf		25a REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10093

10089

1 PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL		d. STREET ADDRESS 200 CALVERT TERRACE	
3. NAME OF DECEASED (Type or print) First Middle Last ELEANOR ELIZABETH RIDENOUR		4. DATE OF DEATH Month Day Year NOVEMBER 27 1967	
5 SEX F	6. COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5-21-16
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	9. AGE (In years last birthday) 51 yrs
11. BIRTHPLACE (County & State, or foreign country) CAMDEN, NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME EUGENE J. PHILLIPS		14. MOTHER'S MAIDEN NAME HAZEL BERRY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 214-09-7289	17. INFORMANT Address HAGERSTOWN MD. MR. J. KENNETH RIDENOUR
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinomatosis 1538 DUE TO (b) Adenocarcinoma of colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 6 mos 4 yr			INTERVAL BETWEEN ONSET AND DEATH 6 mos 4 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-21 , 19 67 , to 11-27 , 19 67 , that (I) (we) last saw the deceased alive on 11-27 , 19 67 , and that death occurred at 7:00 PM , from causes and on the date stated above			
22a. SIGNATURE Edwin G. Riley		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Edwin G. Riley		22d. ADDRESS 1500 Penna, Hagerstown, Md	
23a. BURIAL, CREMATION, BURIAL	23b. DATE THEREOF 11/30/67	23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.	23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.
24. FUNERAL DIRECTOR ADDRESS Wm. J. McMillen, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE DEC 4 1967	25b. REGISTRAR'S SIGNATURE [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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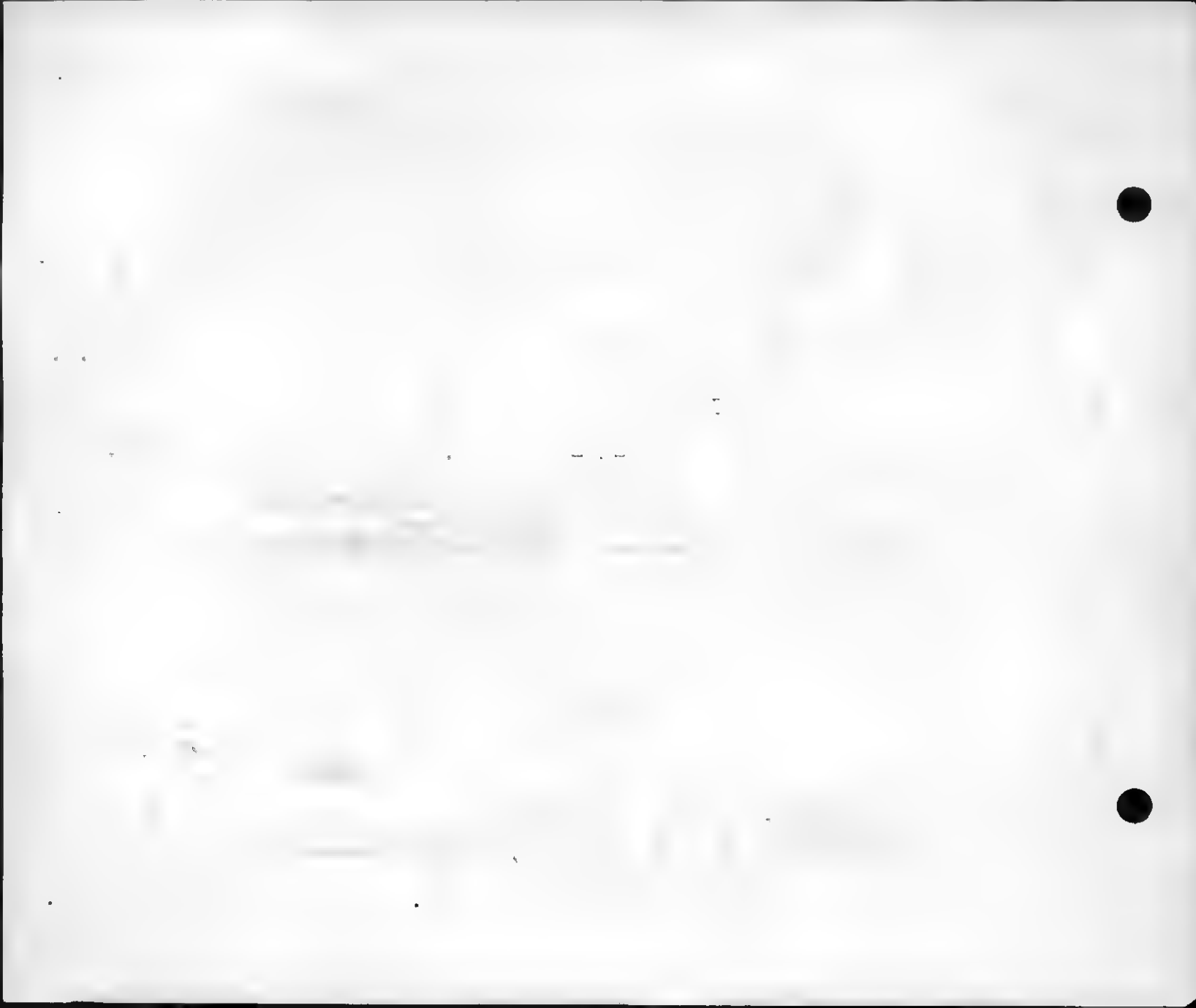
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10000

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL		d. STREET ADDRESS 2360 APPLE TREE DR.	
3. NAME OF DECEASED (Type or print) First Max Middle Edwin Last Ridenour		4. DATE OF DEATH Month Nov Day 16 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/15/1917
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED AGENT		10b. KIND OF BUSINESS OR INDUSTRY INSURANCE CO.	9. AGE (In years for birthday) 50 yrs
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME HARRY CLAUDE RIDENOUR		14. MOTHER'S MAIDEN NAME MARY DERR	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-09-6619	
17. INFORMANT MRS. GLADYS RIDENOUR		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH 1 hr 5 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 'o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-3 , 19 67 , to 11-16 , 19 67 , that (I) (we) last saw the deceased alive on 11-15 , 19 67 , and that death occurred at 7:24 AM , from causes and on the date stated above			
22a. SIGNATURE Edwin G. Riley M.D.		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22b. DATE SIGNED 11-16-67
22c. PHYSICIAN'S NAME (Type) Edwin G. Riley		22d. ADDRESS 1500 Penno, Hagerstown, Md	
23a. BURIAL CREMATION REMAINS (Type) BURIAL	23b. DATE THEREOF 11/18/67	23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.	23d. LOCATION (City or town) (County) (State) HAGERSTOWN WASH. MD.
24. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE NOV 21 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

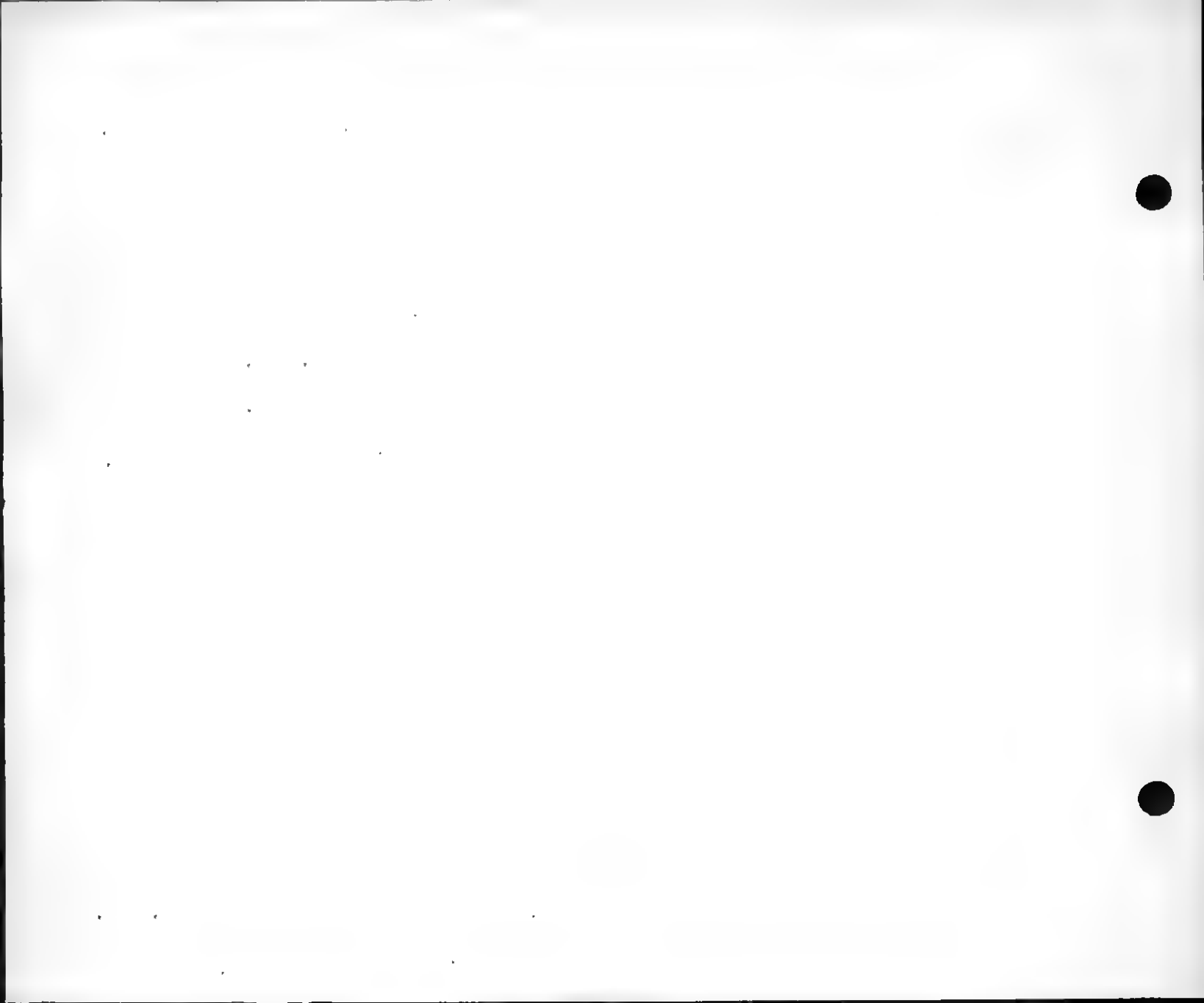
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 20c film #395
12-12-67 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10081

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 weeks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. STREET ADDRESS 4 Willard St.	
3. NAME OF DECEASED (Type or print) First Glenna Middle Wright Last Rinker		4. DATE OF DEATH Month November Day 11 Year 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-23-91
9. AGE (In years last birthday) 75		10. IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Mins. 75	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Burlington, W. Va.	
11. BIRTHPLACE (State or foreign country) Burlington, W. Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph Cornall		14. MOTHER'S MAIDEN NAME Eliza C. Bailey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO none	
17. INFORMANT Marvin Rinker, Cumberland, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple gun shot wounds of DUE TO (b) Abdomen DUE TO (c) Abdomen Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH 6 Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerosis, General + Arteriosclerotic Heart Disease			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Self Inflicted gun shot wound of Abdomen + chest	
20c. TIME OF INJURY Month, Day Year Apr. 5th 11-51-1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hagerstown Wash Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Dittus III M.D.		22. DATE SIGNED 11.12.67	
EXAMINER'S NAME (Type) 217 W. Washington St. Hagerstown, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-14-67	
23c. NAME OF CEMETERY OR CREMATORY Beaver Run Cemetery		23d. LOCATION (City or Town) (County) (State) Burlington, W. Va.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR NOV 15 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Item 21 film #396

1-2-68 mt

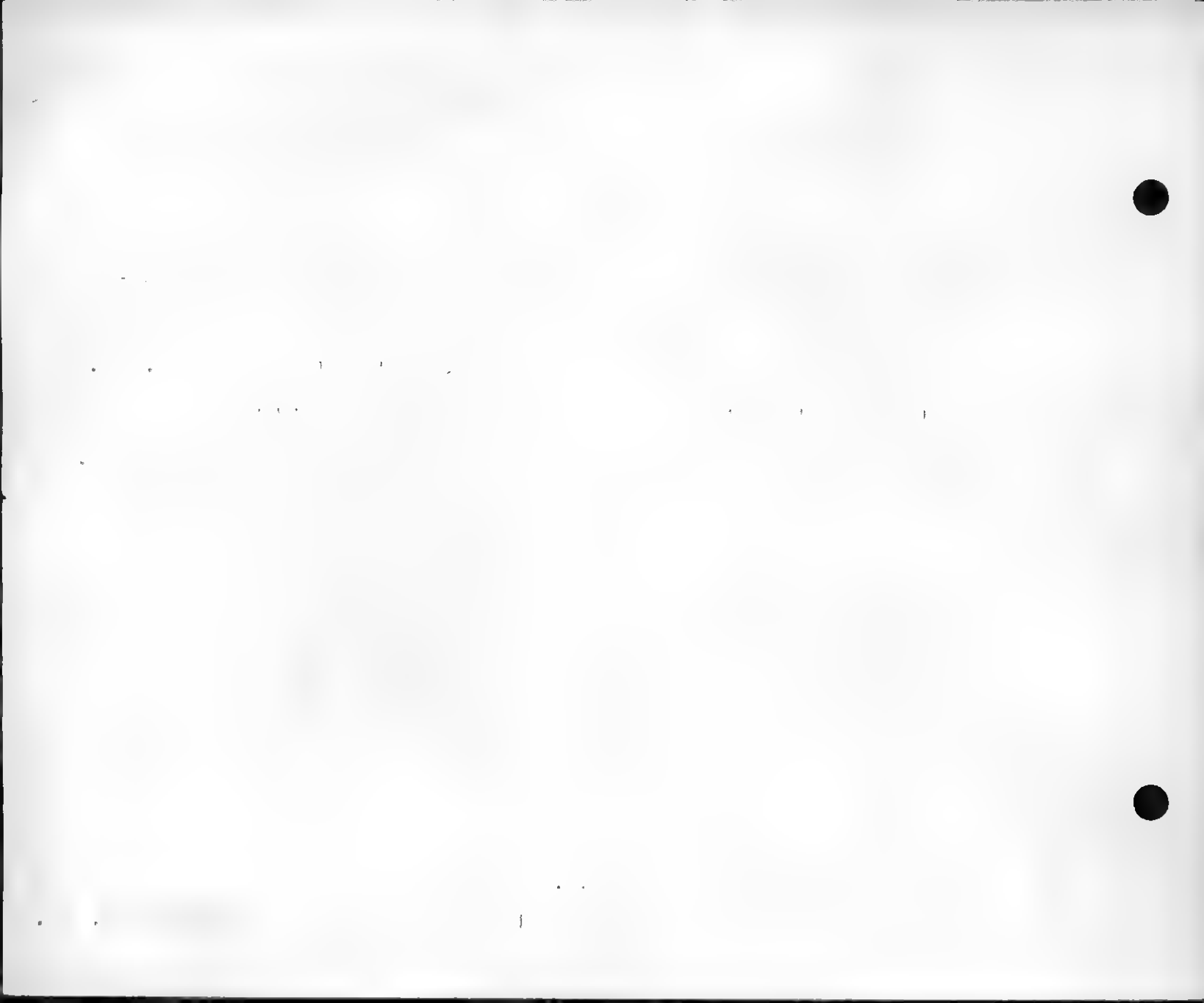
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16102

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1967

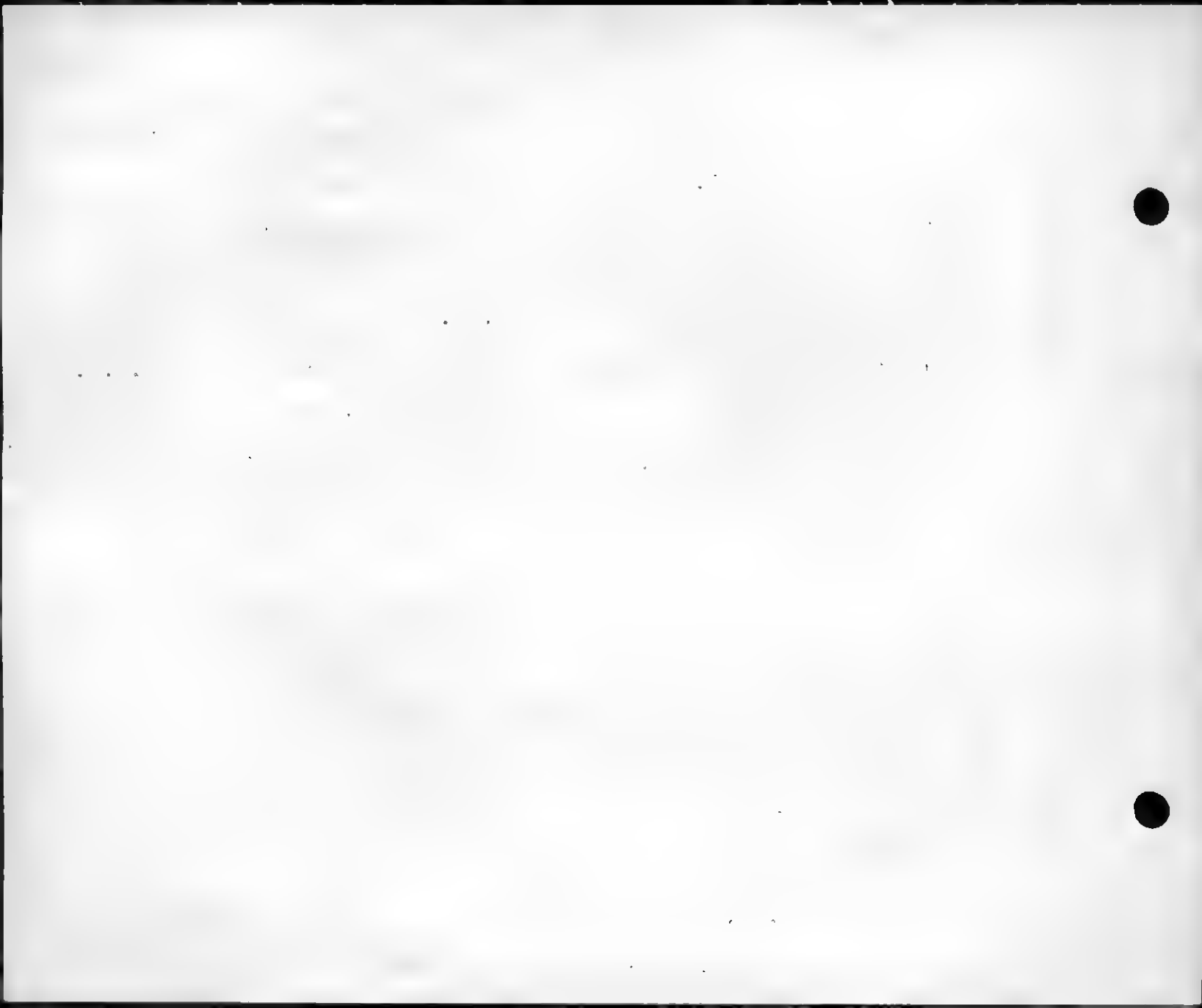
1 PLACE OF DEATH a. COUNTY Washington		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock		c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD 1 Hancock				d. STREET ADDRESS RFD 1 Hancock	
3 NAME OF DECEASED (Type or print) OSWALD		First Middle Last RITZ		4 DATE OF DEATH Month Day Year November 19-20 19 67	
5 SEX White	6 COLOR OR RACE Male	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9/4/1887	9 AGE (In years last birthday) 80 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARM		11 BIRTHPLACE (State or foreign country) PENNSYLVANIA	
13 FATHER'S NAME JOHN CHRISTIAN RITZ			14 MOTHER'S MAIDEN NAME MARGARET HENLINE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO		17 INFORMANT Address ACHSA M KEEFER FORT LOUDEN PENNA.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia DUE TO Carbon Monoxide Poisoning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? c. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) Subject's body was found burned house			
20c. TIME OF INJURY Month, Day, Year Hour a.m. ? p.m. ? 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
		20f. (City or town) Hancock		(County) Wash. (State) MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Edward F. Wilson		EXAMINER'S NAME (Type) / Edward F. Wilson, M.D.		22. DATE SIGNED November 20, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/22/67		23c. NAME OF CEMETERY OR CREMATOR ROGERS HEIGHTS	
24. FUNERAL DIRECTOR Howard J. Hine		ADDRESS Hancock Md		23d. LOCATION (City or Town) (County) (State) RFD 1 HANCOCK, WASH. MD.	
25a. REC'D BY REGISTRAR DATE NOV 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE MARYLAND		b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN MD.		c. LENGTH OF STAY IN ID 18 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MAVALON MANOR NURSING HOME		d. STREET ADDRESS 1208 GLENWOOD AVE		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) CHARLES IGNATIUS ROBEY		4 DATE OF DEATH Month 11 Day 18 Year 1967			
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9.10.1899	9 AGE (In years last birthday) 68 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY ORCHARDIST		11 BIRTHPLACE (County & State, or foreign country) HANCOCK MARYLAND	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN W ROBEY		14. MOTHER'S MAIDEN NAME AMANDA BISHOP	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO. 220.09.7346		17 INFORMANT MARGUERITE E ROBEY 1208 GLENWOOD AVE.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease DUE TO myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last myocardial infarction (b) (c) INTERVAL BETWEEN ONSET AND DEATH unknown					
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) hypertension					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) myocardial infarction			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 11-18		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	
20f (City or town) (County) (State) HAGERSTOWN MD.					
21. I certify that (I) (this hospital) attended the deceased from 7-11-67 , 19 67 , to 11-18 , 19 67 , that (I) (we) last saw the deceased alive on 11-15 , 19 67 , and that death occurred at 11:15 AM , from causes and on the date stated above.					
22a SIGNATURE E. J. Landigosh		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11-20-67	
22c. PHYSICIAN'S NAME (Type) E. J. Landigosh		22d. ADDRESS 300 W. Potomac Highway			
23a BURIAL, CREMATON, REMOVAL (Specify) BURIAL		23b DATE THEREOF 11.21.67		23c NAME OF CEMETERY OR CHURCH MT OLIVET	
23d LOCATION (City or Town) (County) (State) RURAL HANCOCK WASHINGTON					
24 FUNERAL DIRECTOR Howard J. Stone Hancock Md		ADDRESS HANCOCK MD		25a. REC'D BY REGISTRAR NOV 24 1967	
25b REGISTRAR'S SIGNATURE Charles Judge					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

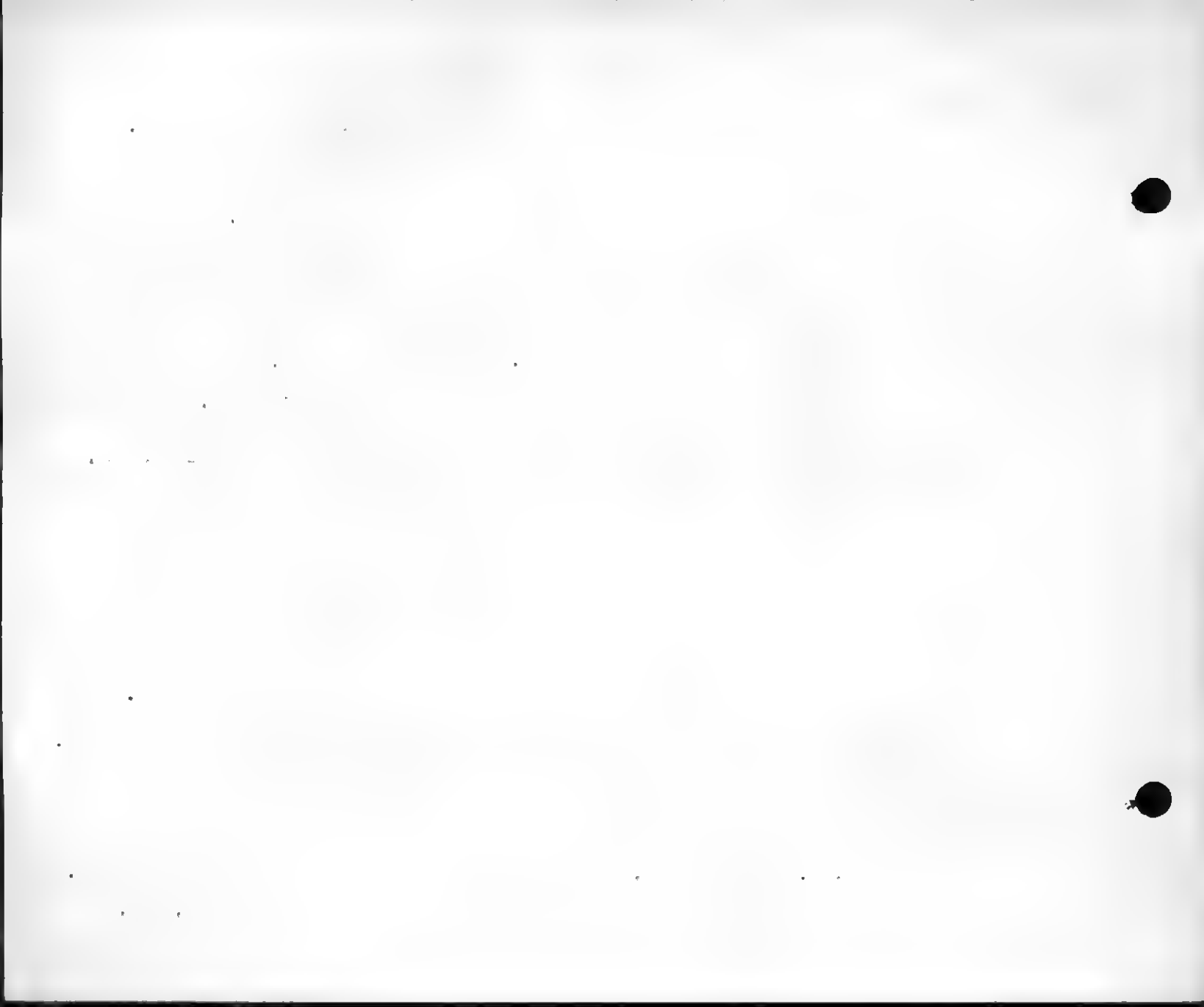
10094

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN TB 30 years d. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) 1019 Florida Ave.		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 1019 Florida Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle William Last Robinson		4. DATE OF DEATH Month November Day 23 Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-27-24
9. AGE (In years last birthday) 43 yrs		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) flask maker		10b. KIND OF BUSINESS OR INDUSTRY sand blast mfg.	
11. BIRTHPLACE (State or foreign country) Smithsburg, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wilbur Robinson		14. MOTHER'S MAIDEN NAME Mary Case.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WW II		16. SOCIAL SECURITY NO 217-12-2645	
17. INFORMANT Mary Robinson, Hagerstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning 7/1/51 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Several minutes DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH Hose attached to exhaust extending into enclosed car.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item B)	
20c. TIME OF INJURY Month, Day, Year Hour 12:30 p.m. 11-23-19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hagerstown, Washington, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		ASSISTANT MED. CA. EXAMINER <input type="checkbox"/> 11-24-67	
22. DATE SIGNED		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-27-67	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City or town) (County) (State) Hagerstown, Md.
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		ADDRESS	
25a. REC'D BY REGISTRAR NOV 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



- 9105

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET
Item #23b,c & d rll #23b,c & d

16895

MEDICAL CERTIFICATION

VR A15 (4)
25M 1/67



2014





MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16106

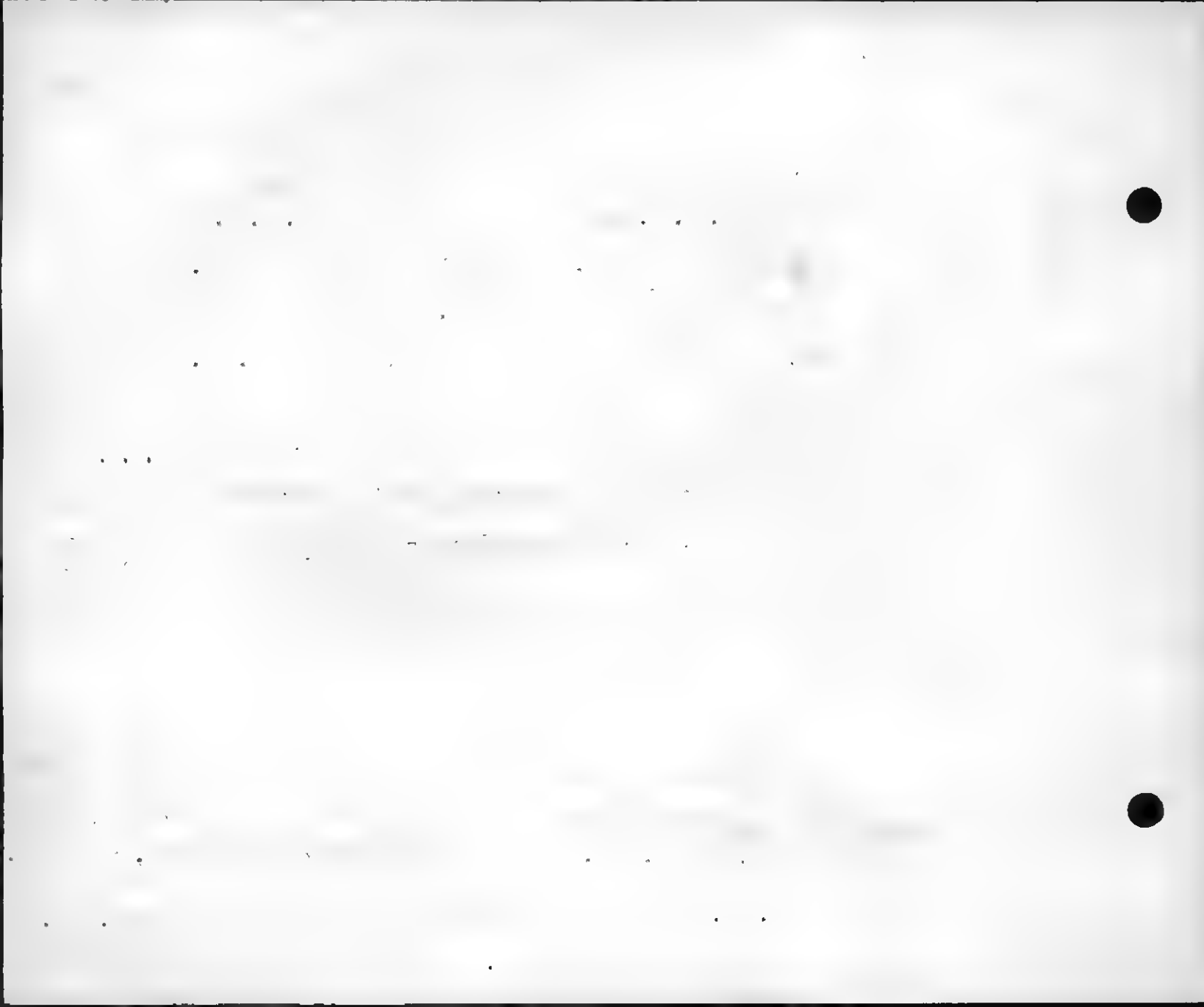
CERTIFICATE OF DEATH

13396

1 PLACE OF DEATH a. COUNTY Washington MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Smithsburg			c. LENGTH OF STAY IN 1b 8 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Smithsburg R. F. D. #2				d. STREET ADDRESS Hagerstown R. F. D. #5		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Sissanna Middle S Last Rudolph				4 DATE OF DEATH Month Nov. Day 10 Year 67			
5 SEX Female		6 COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Feb. 11 1897	
9 AGE (In years last birthday) yrs 70		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY		9 AGE (In years last birthday) yrs 70	
11 BIRTHPLACE (County & State, or foreign country) Maugansville Wash. Co.				12 CITIZEN OF WHAT COUNTRY? USA			
13 FATHER'S NAME David H Horst				14 MOTHER'S MAIDEN NAME Mary Eshelman			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16 SOCIAL SECURITY NO. no		17. INFORMANT Address Virius F Rudolph Hagerstown R.F.D.#5			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pleural & Generalized Abdominal Metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Malignant Paraganglioma - site of origin uncertain DUE TO (c) uncertain						INTERVAL BETWEEN ONSET AND DEATH 10 months 10 months certain	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 1 of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Jan 27 , 19 67 to Nov 10 , 19 67 , that (I) (we) last saw the deceased alive on Nov 6 , 19 67 , and that death occurred at 9 AM, from causes and on the date stated above.							
22a. SIGNATURE 				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED Nov 11, 1967	
22c. PHYSICIAN'S NAME (Type) William T. Layman, M.D.				22d. ADDRESS 100 Professional Arts Bldg, Hagerstown.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 13. 67		23c. NAME OF CEMETERY OR CREMATORY Stouffer Mennonite Cemetery		23d. LOCATION (City or Town) (County) (State) Smithsburg Wash. Md.	
24 FUNERAL DIRECTOR Minnich Funeral Home				ADDRESS Smithsburg Md.		25a. REC'D BY REGISTRAR NOV 14 1967	
				25b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

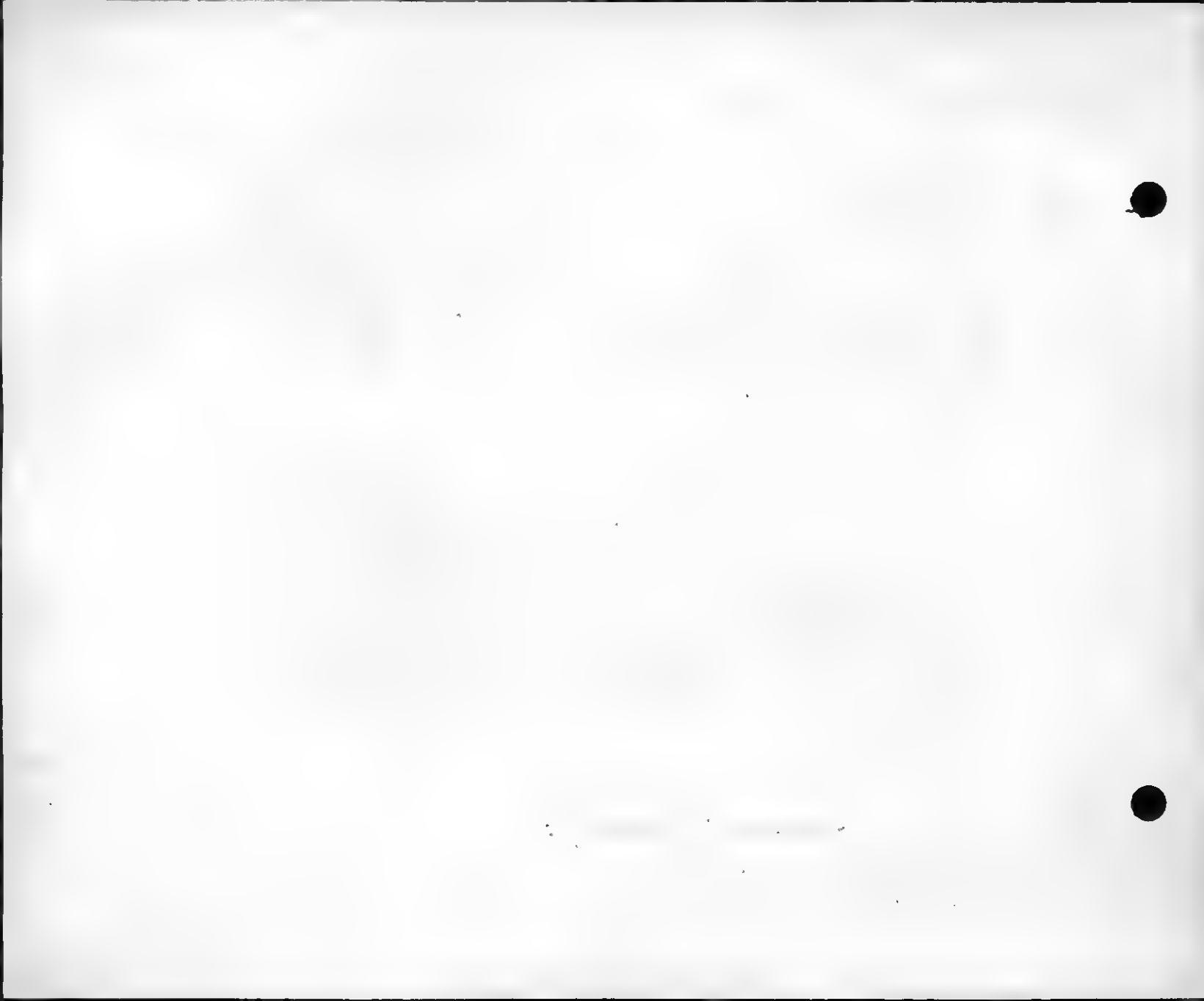
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

19107

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15087

1 PLACE OF DEATH a COUNTY Washington MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b STATE Maryland c COUNTY Frederick	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c LENGTH OF STAY IN TB 20 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d STREET ADDRESS Braddock Heights	
3 NAME OF DECEASED (Type or print) First Rossiter Middle L. Last Seward		4 DATE OF DEATH Month November Day 27 Year 19 67	
5 SEX Male	6 CO. OR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Dec. 15, 1891
9 AGE (in years last birthday) 75 yrs		F UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broker		10b. KIND OF BUSINESS OR INDUSTRY Stock Exchange	
11 BIRTHPLACE (State or foreign country) New York		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William C. Seward		14 MOTHER'S MAIDEN NAME Anna P. Plumb	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes give war or dates of service) Yes W.W. I		16 SOCIAL SECURITY NO. 114-14-9942	
17. INFORMANT Avadna Seward		Address Braddock Heights, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest following post-op craniotomy for subdural hematoma and brain laceration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to (c) Due to			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Severe coronary atherosclerotic disease			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH Patient fell, hitting head on floor in Post Office at Frederick, Maryland		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Post office	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 11/? p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Post office		20f. (City or town) (County) (State) Frederick, Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Howard N. Weeks, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> 11/28/67 ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 22. DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 580 Northern Avenue Address (Street, city, town, or county) Hagerstown, Md.	
23a. BURIAL CREMATION Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> (Specify)		23b. DATE THEREOF Nov. 30, 1967	
23c. NAME OF CEMETERY OR CREMATORY Reform Cemetery		23d. LOCATION (City or town) (County) (State) Middletown Fred. Md.	
24. FUNERAL DIRECTOR Gladhill Co.		ADDRESS Middletown, Md.	
25a. REC'D BY REGISTRAR DATE NOV 30 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16098

1 PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN lb 5 Days		Rural, Boonsboro 21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last Lucy I. Shank		4 DATE OF DEATH Month Day Year Nov. 24 19 67	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2/12/1877
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Near Mercersburg Pa.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Benedict		14. MOTHER'S MAIDEN NAME Sarah Keller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16 SOCIAL SECURITY NO. 179-12-3688B.	
17. INFORMANT D. Jerome Shank, Boonsboro Md., Route #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized peritonitis 4 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Perforation of sigmoid colon 4 days (c) Carcinoma of recto-sigmoid colon 6 mos		INTERVAL BETWEEN ONSET AND DEATH 4 days 4 days 6 mos	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Smility		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 20, 1967, to Nov. 24, 1967, that (I) last saw the deceased alive on Nov. 24 1967, and that death occurred at 1:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE John A. Moran		22b. DATE SIGNED 11/25/67	
22c. PHYSICIAN'S NAME (Type) John A. Moran		22d ADDRESS 215W Washington St. Nazareth, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 11/27/67	
23c NAME OF CEMETERY OR CREMATORY Green Hill		23d LOCATION (City or Town) (County) (State) Waynesboro, Franklin Co., Pa.	
24. FUNERAL DIRECTOR Walter G. Groves		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE NOV 28 1967	

Waynesboro Pa.

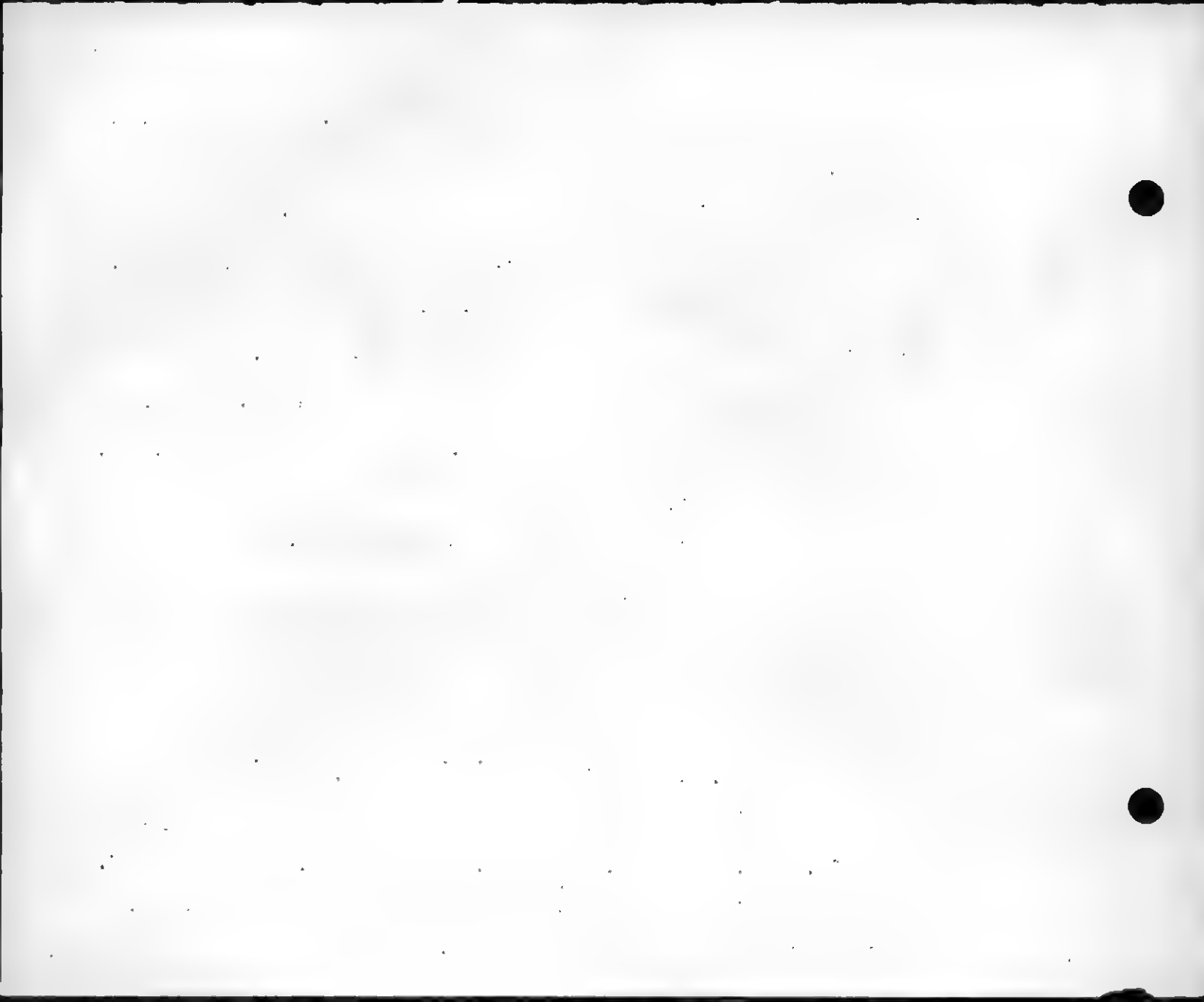


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VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 38 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 135 North Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Ann Norma Shannon						4. DATE OF DEATH Month November Day 4 Year 1967					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-26-1887		9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Progress, Penna.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Henry Knupp						14. MOTHER'S MAIDEN NAME Mary A. Schaeffer					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Roy D. Shannon, Hagerstown, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 200A DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio Vascular Disease DUE TO (c) Diabetes										INTERVAL BETWEEN ONSET AND DEATH 36 hours 5 years 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Aug. 1, 1967, to Nov. 4, 1967, that (I) (we) last saw the deceased alive on Nov. 3, 1967, and that death occurred at 4 A.M. from the causes and on the date stated above.											
22a. SIGNATURE 						22b. DATE SIGNED 11-4-67		22c. PHYSICIAN'S NAME (Print) Dr. E. W. Ditto, Jr.			
22d. ADDRESS 215 W. Washington St., Hagerstown, Md.						22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 11-6-67		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery				23d. LOCATION (City, town or county) (State) Hagerstown, Md.			
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.						25a. REC'D BY REGISTRAR NOV 8 1967		25b. REGISTRAR'S SIGNATURE 			



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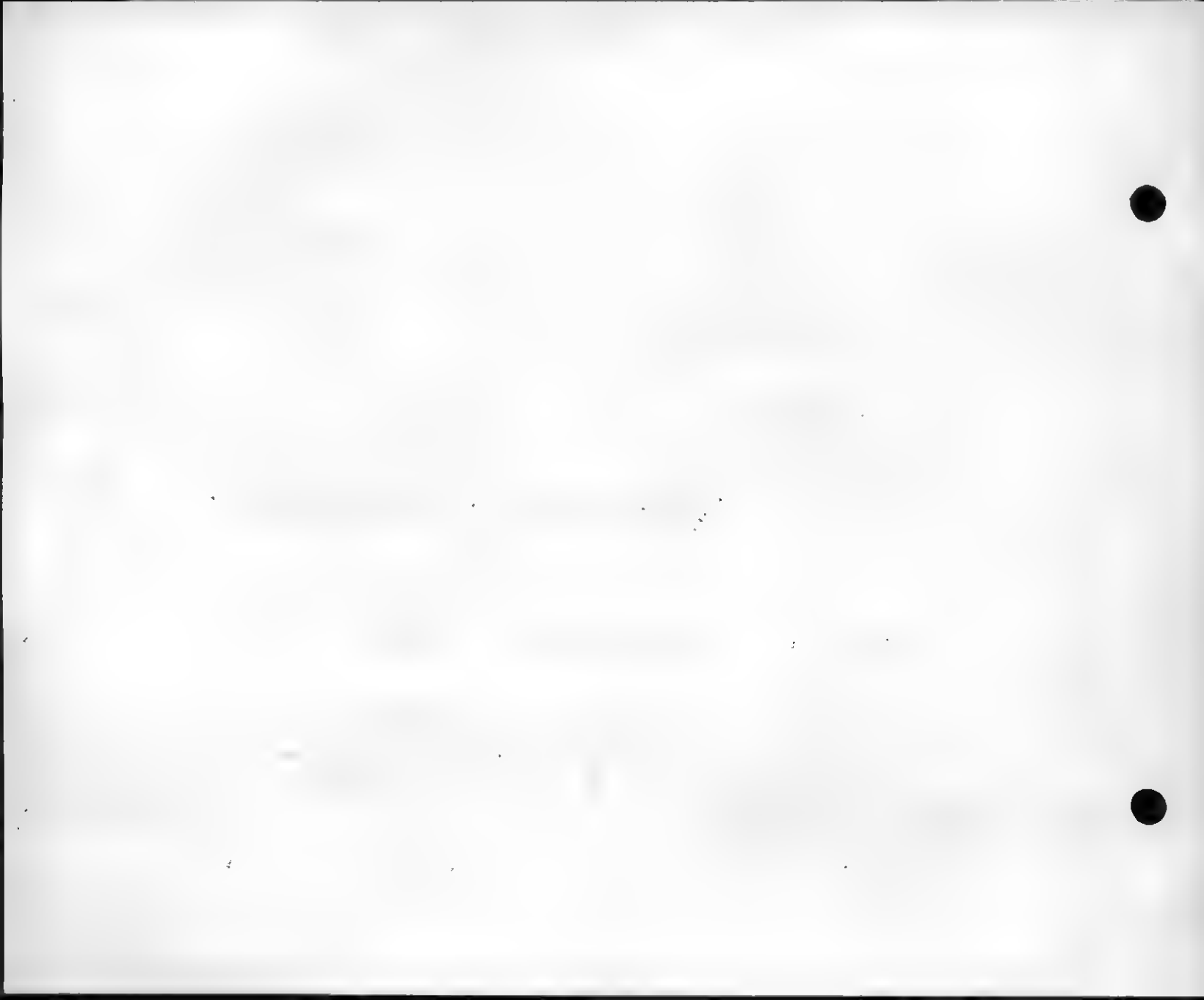
16110

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16100

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN TB 4 days		2. USUAL RESIDENCE (Where deceased lived, if inst. lichen - Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Middletown 10-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ruth		First A.		Middle Sheffer	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF DEATH Nov. 17 1967		9. AGE (In years lost birthday) 65 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Fred. Co. Maryland	
13. FATHER'S NAME Victor Alexander		14. MOTHER'S MAIDEN NAME Rose Toms			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 		17. INTERVIEW ADDRESS Frank Sheffer Middletown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Common Duct & Biliary Obstruction DUE TO (b) (Adenocarcinoma) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					INTERVAL BETWEEN ONSET AND DEATH 1 mo +
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiovascular Disease					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 13, 1967 to Nov. 17, 1967 that (I) (we) last saw the deceased alive on Nov. 17 1967 , and that death occurred at 5:30 P.M. from causes and on the date stated above.					
22a. SIGNATURE Richard V. Hauver		22b. DATE SIGNED Nov. 18, 67		22c. PHYSICIAN'S NAME (Type) RICHARD V. HAUSER	
22d. ADDRESS Hagerstown, Md		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 20, 1967		23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery	
23d. LOCATION (City or Town) Middletown		(County) Fred.		(State) Md.	
24. FUNERAL DIRECTOR Gladhill Company		ADDRESS Middletown, Md.		25a. REC'D BY REGISTRAR DATE Nov. 21 1967	
				25b. REGISTRAR'S SIGNATURE Charles Jones	

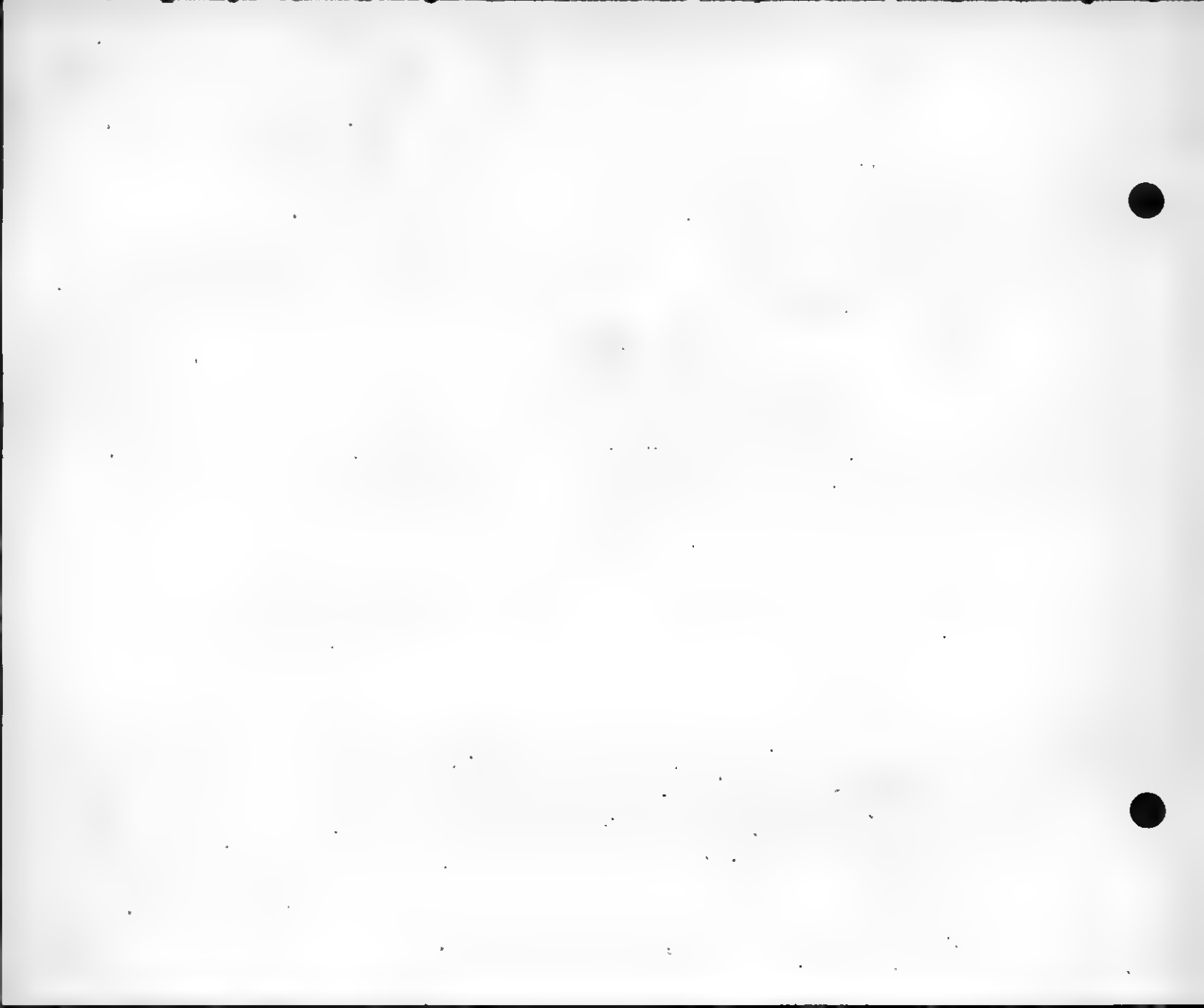


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 60 years			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 136 East Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ernest Middle Linwood Last Shirey				4. DATE OF DEATH Month November Day 3 Year 1967			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-14-95	
9. AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) owner		11. BIRTHPLACE (County & State, or foreign country) Jersey Shore, Penna.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Shirey				14. MOTHER'S MAIDEN NAME Chatherine Heffelman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-20-8891		17. INFORMANT Irene Shirey, Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Pulmonary Emphysema - Bronchial Asthma						INTERVAL BETWEEN ONSET AND DEATH years	
19a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 2 of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 11, 1962 to 11/3, 1967 , that (I) (we) last saw the deceased alive on 11/3, 1967 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE A. Mandell				22b. DATE SIGNED 11/3/67			
22c. PHYSICIAN'S NAME (Type) A. MANDELL, M.D.				22d. ADDRESS 301 E. ANTICAM ST			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 11-6-67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.				25a. REC'D BY REGISTRAR NOV 8 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



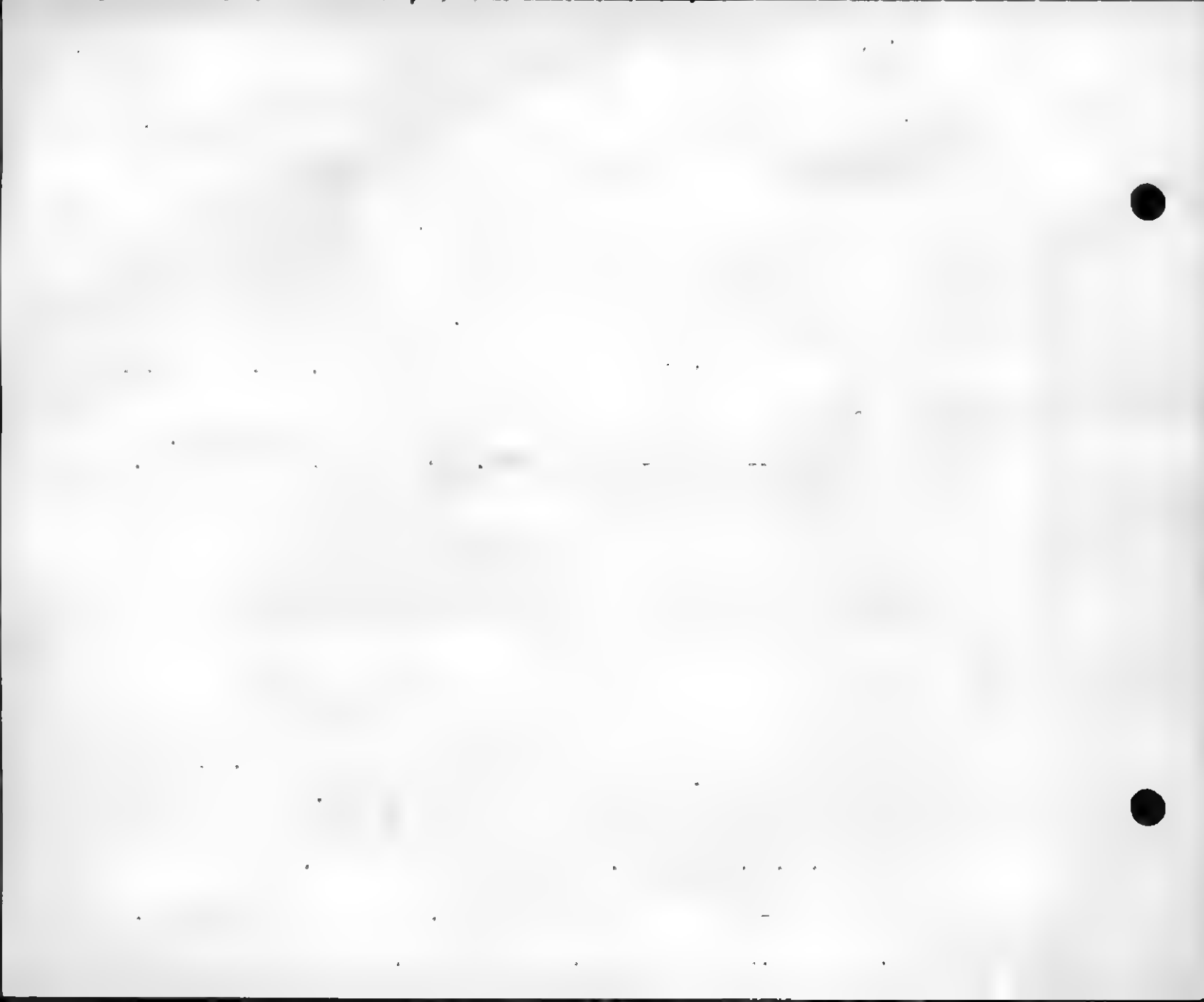
CERTIFICATE OF DEATH

16102

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Fairplay c. LENGTH OF STAY IN b 10 Yrs.		2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Fairplay	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rfd. 1		d. STREET ADDRESS Rfd. 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Grace May Shoop		4. DATE OF DEATH Month Day Year November 2 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 15, 1893 9. AGE (in years last birthday) yrs 74
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Frederick Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Haupt		14. MOTHER'S MAIDEN NAME Ida Green	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO 220-26-0678	
17. INFORMANT Mrs. Irene Palmer, 717 George St.		Address Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4221 IMMEDIATE CAUSE (a) Pneumonitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Cerebral Arteriosclerosis (Hemiplegia) DUE TO (c) Arteriosclerotic Cardio Vascular Disease		INTERVA. BETWEEN ONSET AND DEATH 3 days 1 year 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 1, 1967 , to Nov. 2, 1967 , that (I) (we) last saw the deceased alive on Nov. 1, 1967 , and that death occurred at 1:30 PM , from causes and on the date stated above.			
22a. SIGNATURE E. W. Ditto, Jr.		22b. DATE SIGNED 11-3-67	
22c. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.		22d. ADDRESS Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-4-67	23c. NAME OF CEMETERY OR CREMATORY Beaver Creek, Lut. Cem.	23d. LOCATION (City or Town) (County) (State) Beaver Creek, Md.
24. FUNERAL DIRECTOR John H. Bast, Jr., 112 N. Main St., Boonsboro, Md.		25a. REC'D BY REGISTRAR NOV 6 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

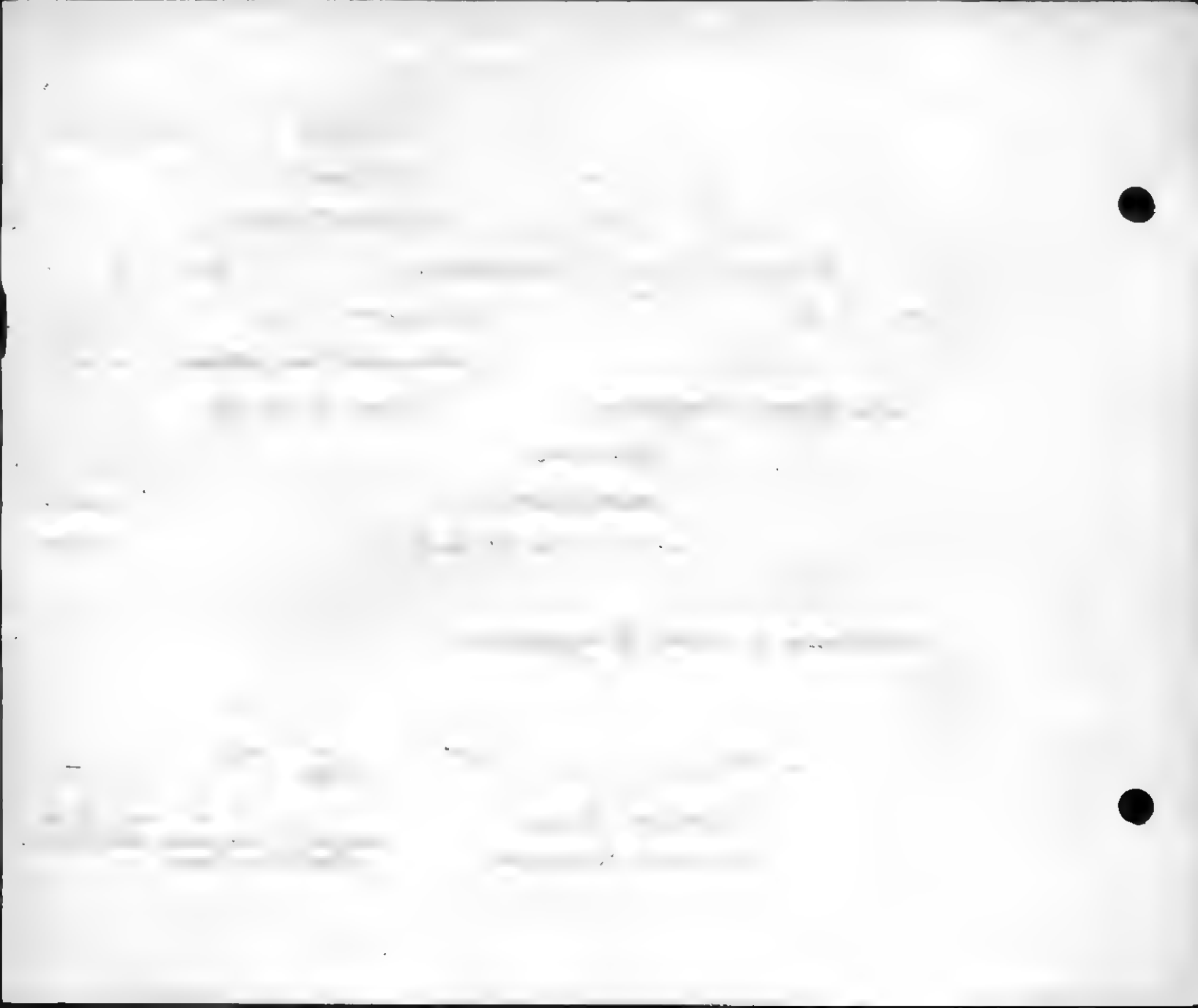
16113

15103

1 PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 45 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Richard Daniel Stonebraker		4. DATE OF DEATH Month Nov. Day 3 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10, 1894
9. AGE (In years lost birthday) 73 yrs		10. IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min. 73	
11. BIRTHPLACE (County & State, or foreign country) Washington County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Clarence Stonebraker		14. MOTHER'S MAIDEN NAME Sara W. Dalby	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES W.W.I.		16. SOCIAL SECURITY NO 705-10-6840	
17. INFORMANT MRS. MARY G. STONEBRAKER, HAGERSTOWN, MD.		18. ADDRESS 712 SUNSET AVE.	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) carcinoma of lung DUE TO (c)		20. INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (1) Carcinoma of prostate (2) Hypertension		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
23a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	23b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	23c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	23d. (City or town) (County) (State)
24. I certify that (1) (this hospital) attended the deceased from Sept. 19, 1967 , to Nov. 3, 1967 , that (2) (we) last saw the deceased alive on Nov. 3, 1967 , and that death occurred at 9:00 AM , from causes and on the date stated above			
25a. SIGNATURE Victor L. Ramos, M.D.		25b. DATE SIGNED Nov. 3, 1967	
26a. PHYSICIAN'S NAME (Type) Victor L. Ramos, M.D.		26b. ADDRESS Western Maryland State Hospital Hagerstown, Md.	
27a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	27b. DATE THEREOF 11/6/67	27c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY	27d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD.
28a. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND		28b. REC'D BY REGISTRAR Nov 6 1967	
29a. REGISTRAR'S SIGNATURE Charles Judge		29b. DATE Nov 6 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16114

10104

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institut on Residence before adm ssion) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN life life			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 433 Elizabeth Ave.			
3. NAME OF DECEASED (Type or print) First Evelyn Middle S. Last Stouffer				4. DATE OF DEATH Month November Day 29 Year 19 67			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-30-97	9. AGE (n years last birthday) yrs 69	F UNDER 1 YEAR Months Days Hours Min		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress			10b. KIND OF BUSINESS OR INDUSTRY laundry		11. BIRTHPLACE (County & State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME William Secord				14. MOTHER'S MAIDEN NAME 1012			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 215-14-2257		17. INFORMANT Kenneth Stouffer, Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Hypertension Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 4 yrs (c)							INTERVAL BETWEEN ONSET AND DEATH 4 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/16 , 19 65 to 11/29 , 19 67 , that (I) (we) lost saw the deceased alive on 11/3 , 19 67 , and that death occurred at 4:40 M, from causes and on the date stated above.							
22a. SIGNATURE Donald E. Martin M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/29/67	
22c. PHYSICIAN'S NAME (Type) Donald E. Martin, M.D.				22d. ADDRESS 418 N. Potomac St., Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 12-2-67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.				25a. REC'D BY REGISTRAR DATE DEC 6 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

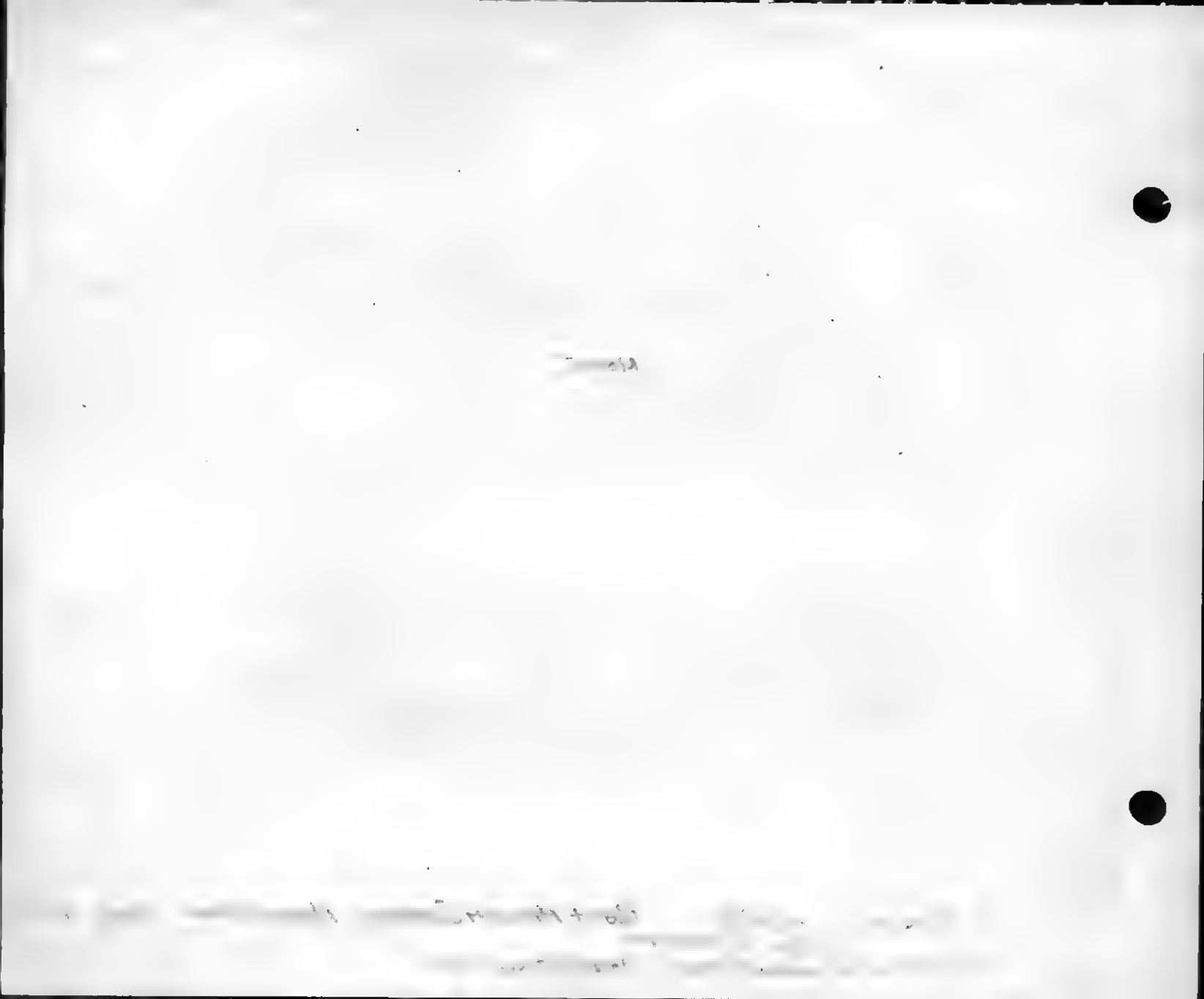
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN IL 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON County Hosp		d. STREET ADDRESS 708 N. Muh Berry St.	
3. NAME OF DECEASED (Type or print) IVAN Lee TAGG III		4. DATE OF DEATH NOV 10 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 8, 1967
9. AGE (in years last birthday) 2 yrs		10. IF UNDER 1 YEAR Months 2 Days 10 Hours 19 Min 67	11. IF UNDER 24 HRS Months 2 Days 10 Hours 19 Min 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BABY		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (County & State, or foreign country) WASHINGTON MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME IVAN Lee TAGG, JR.		14. MOTHER'S MAIDEN NAME YOLANDA LARAY ILM BROSE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT HOSPITAL Records WASHINGTON Co.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYALINE MEMBRANE DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PREMATURITY			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from NOV 8, 1967 to NOV 10, 1967 that (I) (we) last saw the deceased alive on NOV 10 1967 , and that death occurred at 9:30 P M, from causes and on the date stated above.			
22a. SIGNATURE Ronald E Keyser		22b. DATE SIGNED NOV 10, 1967	
22c. PHYSICIAN'S NAME (Type) RONALD EDWARD KEYSER		22d. ADDRESS 119 KING ST HAGERSTOWN MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/13/67	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown Wash MD
24. FUNERAL DIRECTOR Wm C. Host		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE NOV 13 1967	



16116

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

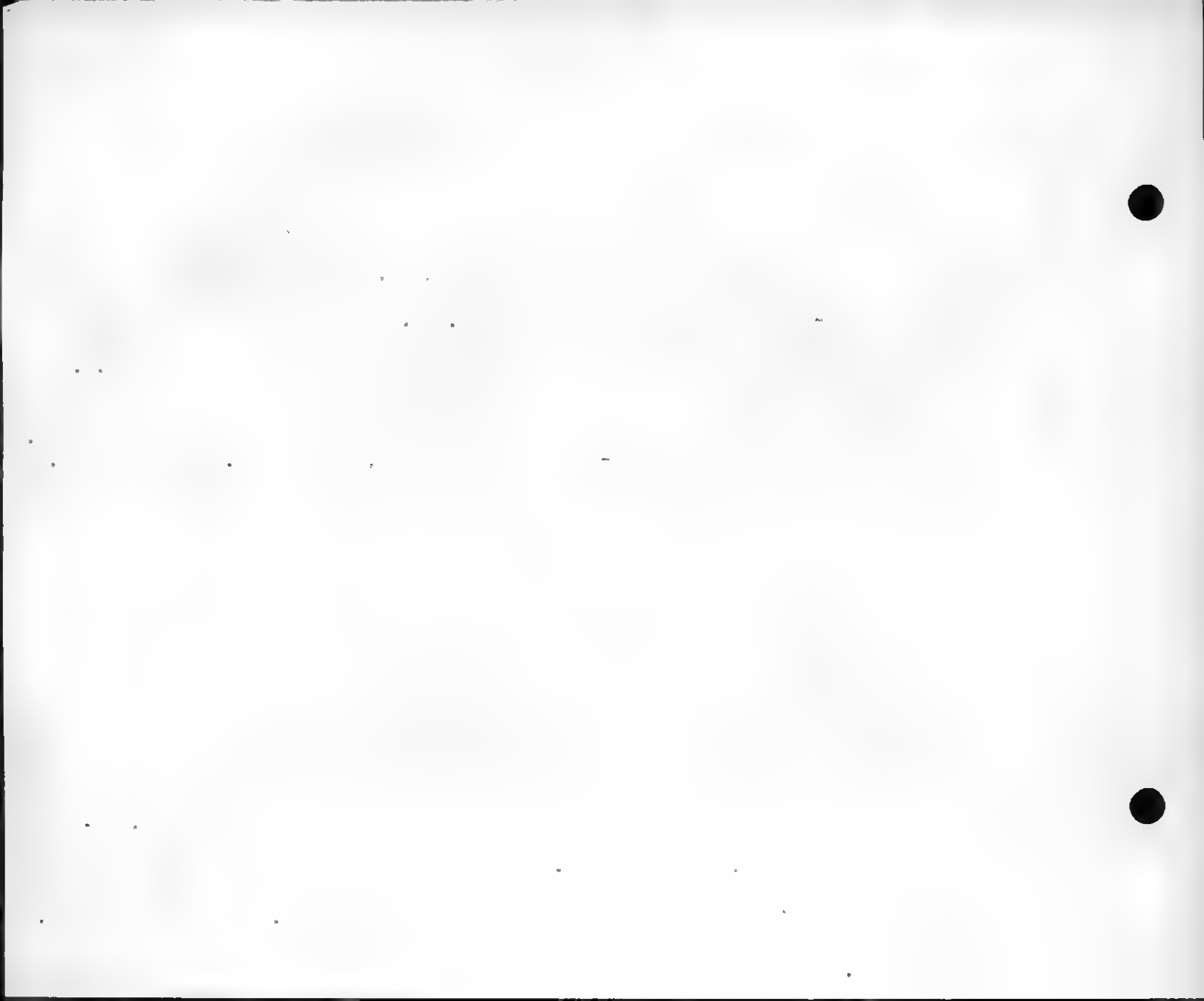
CERTIFICATE OF DEATH

16106

1 PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before adm ssion) a. STATE FLORIDA b. COUNTY BROWARD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 1 MO. 15 DAYS c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT LAUDERDALE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS 2025 N.E. 25 th. STREET	
3 NAME OF DECEASED (Type or print) First Middle Last HERBERT EDWARD THOMAS, SR.		4. DATE OF DEATH Month Day Year NOVEMBER 18, 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 27, 1876
9. AGE (In years last birthday) 90 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED STEELWORKER		10b. KIND OF BUSINESS OR INDUSTRY STEELMILL	
11 BIRTHPLACE (County & State, or foreign country) WALES		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THEODORE L. THOMAS		14. MOTHER'S MAIDEN NAME ANN DAVIES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO ***		16. SOCIAL SECURITY NO 193-03-2983	
17. INFORMANT MR. HERBERT E. THOMAS, JR.		340 CHERRY TREE CIR. HAGERSTOWN, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral lobular pneumonia + DUE TO Benign nephrosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO (b) Generalized arteriosclerosis + cerebral thrombosis + hemiplegia and (c) Diabetes mellitus			INTERVAL BETWEEN ONSET AND DEATH 7 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) Diagnosed hypertrophy, Benign			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Nov. 11, 19 67 , to Nov. 18, 19 67 , that (I) (the hospital) last saw the deceased alive on Nov. 18, 19 67 , and that death occurred at 12:30 M, from causes and on the date stated above.			
22a. SIGNATURE Edward W. Ditto, III M.D.		22b. DATE SIGNED NOV. 19, 1967	
22c. PHYSICIAN'S NAME (Type) EDWARD W. DITTO, III, M.D.		22d. ADDRESS 217 W. WASHINGTON ST. HAGERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE THEREOF 11/19/67	23c. NAME OF CEMETERY OR CREMATORY LAUDERDALE MEMORIAL GARDENS, FT. LAUDERDALE, FLA.	23d. LOCATION (City or Town) BROWARD CO. (State)
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.		25a. REC'D BY REGISTRAR NOV 21 1967 25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



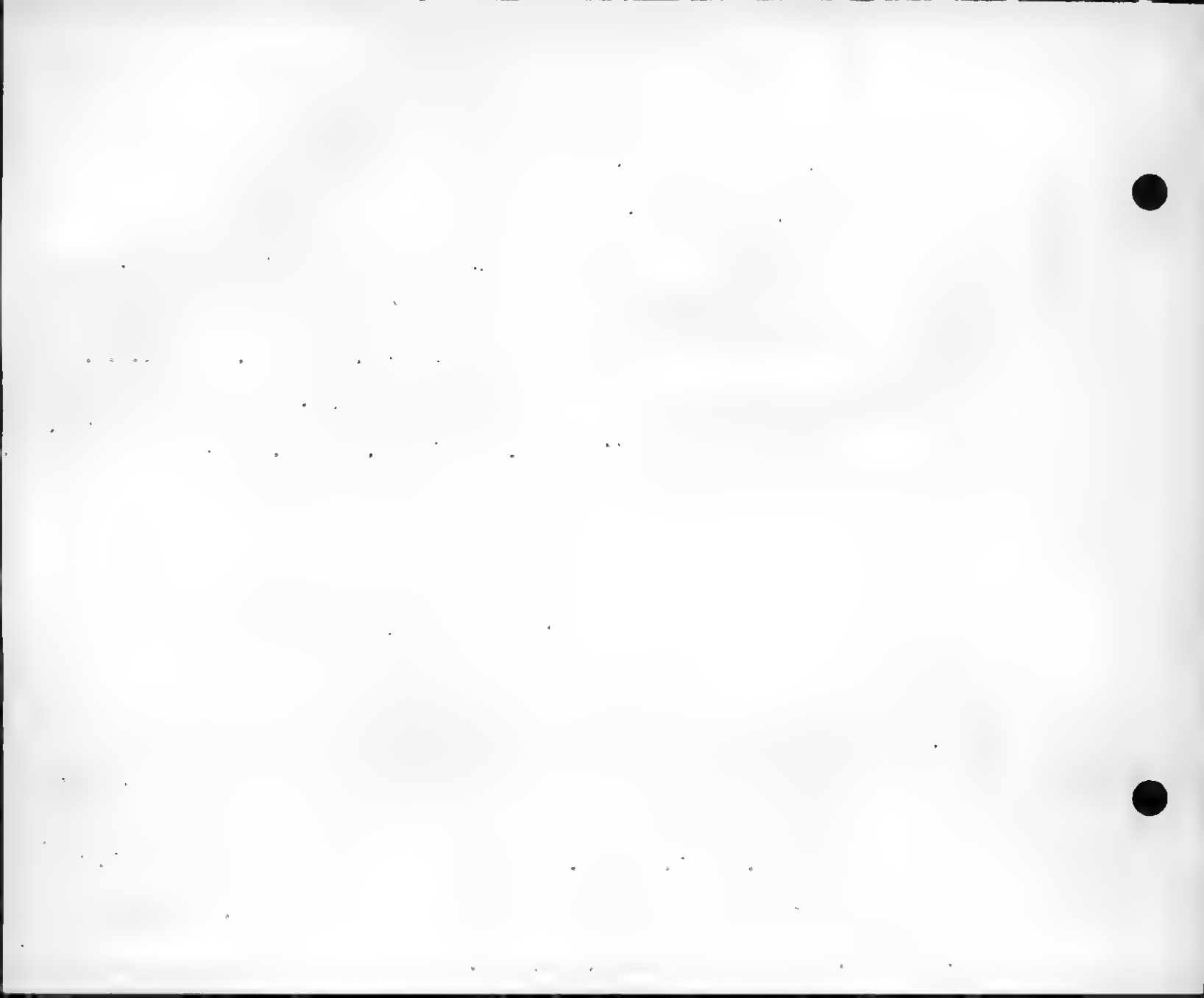
FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISM (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 36 YEARS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON COUNTY HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 50 EAST FRANKLIN STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First MARY Middle SUSAN Last THOMAS			4. DATE OF DEATH Month NOVEMBER Day 15 Year 1967						
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 31, 1882		9. AGE (In years last birthday) 85 yrs. IF UNDER 1 YEAR: Months 15 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) FROSTBURG, MARYLAND.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY HARRIS					14. MOTHER'S MAIDEN NAME JOHANNA JONES				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 219-54-1103		17. INFORMANT MR. CLIFFORD N. THOMAS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia - Secondary to 704.0 DUE TO Fracture Neck Left Femur Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 5 days DUE TO (c) 5 days									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Polycythemia Vera @ Benign Nephrosclerosis @ Erythremia									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Tripped and fell at home				20c. TIME OF INJURY Month, Day, Year 9:45 a.m. 11-10-19 67					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) WASH (County) MD (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Edward W. Ditto, III M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) EDWARD W. DITTO, III, M.D.				22. DATE SIGNED 11/17/67 217 W. WASH. ST. HAGERSTOWN, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/18/67		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION (City, town or county) (State) HAGERSTOWN, WASH. CO. MD.			
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.				25a. REC'D BY REGISTRAR NOV 21 1967		25b. REGISTRAR'S SIGNATURE John's Judge			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15ME
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>20 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>Franklin</u> <u>421 W. Washington St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Paul French Troxell</u>				4. DATE OF DEATH Month Day Year <u>November 25 19 67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 2, 1913</u>	9. AGE (In years last birthday) yrs <u>54</u>	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. US. AL. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>County Rds. Dept.</u>		11. BIRTHPLACE (State or foreign country) <u>Funkstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William R. Troxell</u>				14. MOTHER'S MAIDEN NAME <u>Etta Mae French</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes WW 2</u>		16. SOCIAL SECURITY NO <u>213-03-0625</u>		17. INFORMANT <u>Franklin</u> Address <u>Hagerstown, Md.</u> <u>Mrs. Ethel Troxell 421 W. Washington St.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (c) <u>Diabetes</u> Several years						INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Dr. E. W. Ditto, Jr.</u> M.D.				22. DATE SIGNED <u>11-27-67</u>			
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/28/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Lawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. C. Shank</u> ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 30 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

10/10/10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

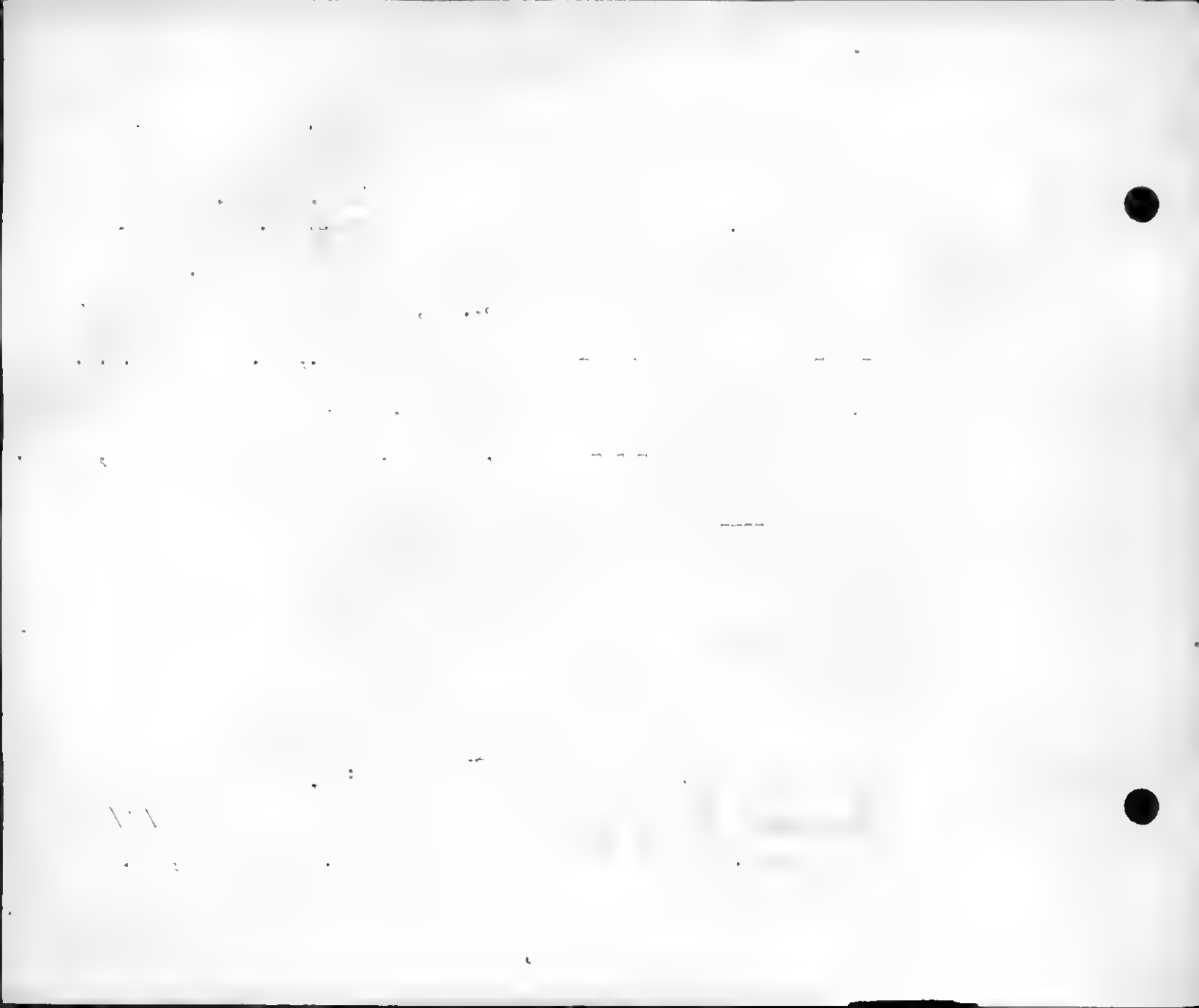
10119

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15109

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Penna. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waynesboro	
c. LENGTH OF STAY IN TB 7 hrs		d. STREET ADDRESS 44 W. 4th St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Co. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Terri Middle Lynn Last Valentine		4. DATE OF DEATH Month Nov. Day 23 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 22, 1967
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS Hours Min.		12. IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (County & State, or foreign country) Washington Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James C. Valentine		14. MOTHER'S MAIDEN NAME Nancy R. Miller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. - - -	
17. INFORMANT Mr. James C. Valentine		Address Waynesboro, Penna.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suspected Intra Ventricular Hemorrhage 5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Primary Pulmonary Atelectasis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prematurity			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour "a.m." p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/22 , 19 67 , to 11/23 , 19 67 , that (I) (we) last saw the deceased alive on 11/23/ 19 67 , and that death occurred at 3:20 M, from causes and on the date stated above.			
22a. SIGNATURE Ronald E. Keyser M.D.		22b. DATE SIGNED 11/23/1967	
22c. PHYSICIAN'S NAME (Type) Ronald E. Keyser		22d. ADDRESS 101 King St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/25/1967	23c. NAME OF CEMETERY OR CREMATORY Burns Hill	23d. LOCATION (City or Town) (County) (State) Waynesboro, Franklin, Penna.
24. FUNERAL DIRECTOR Wallace J. Ghorz		25a. REC'D BY REGISTRAR NOV 27 1967	
ADDRESS Waynesboro, Penna.		25b. REGISTRAR'S SIGNATURE W. Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

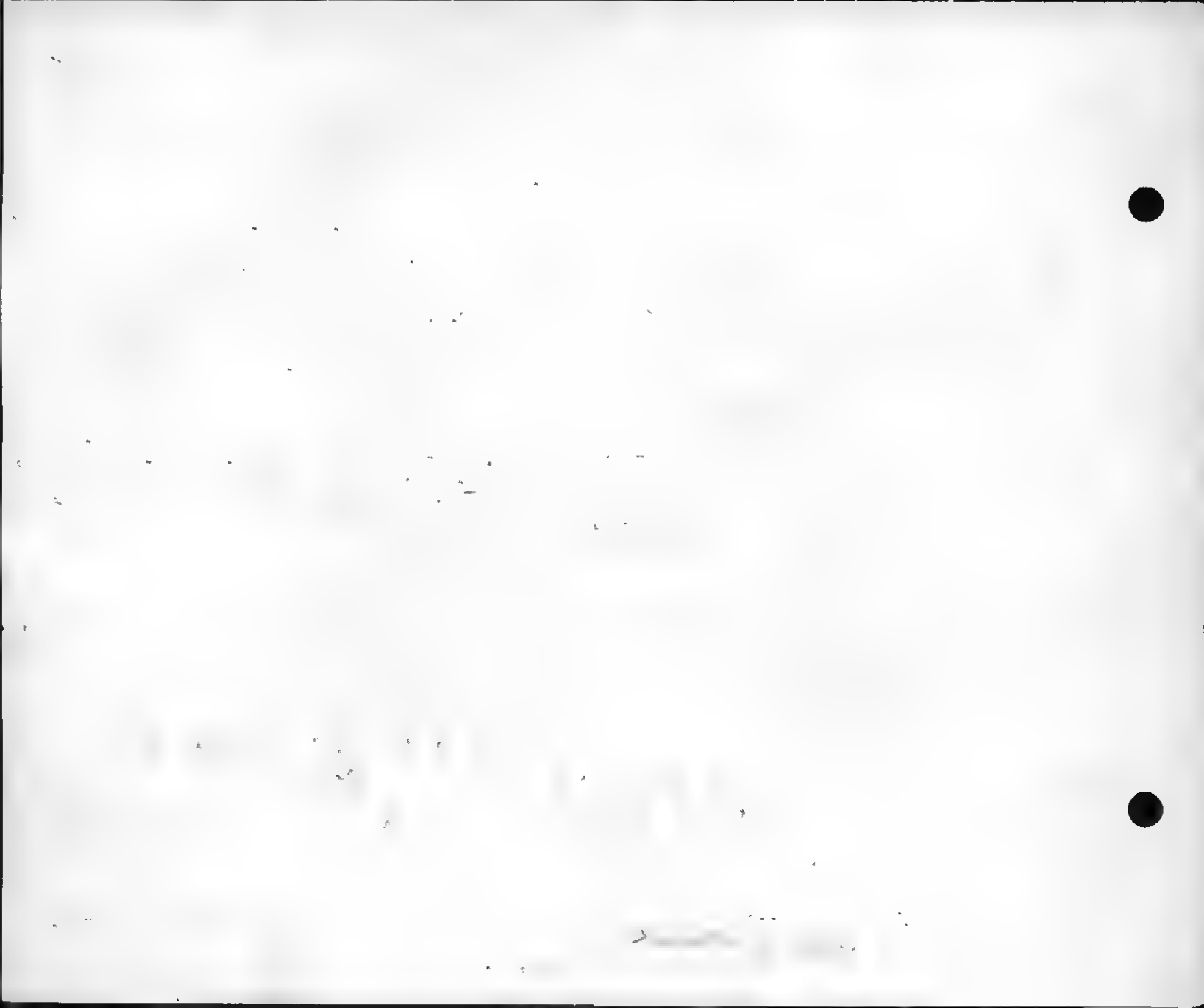
CERTIFICATE OF DEATH

16110

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN lb <u>31 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>113 E. Lee St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>Mae</u> Last <u>Ward</u>		4. DATE OF DEATH Month <u>November</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1882</u> <u>Dec. 9, 1892</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Burrall</u>		14. MOTHER'S MAIDEN NAME <u>Kathleen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-09-9565</u>	
17. INFORMANT <u>Mrs. Gertrude Jones</u>		Address <u>Md. 113 E. Lee St. Hagerstown.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Arterial Emboli</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>4 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-21</u> , 19 <u>67</u> to <u>11-24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-24</u> , 19 <u>67</u> and that death occurred at <u>9:50 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>D. J. Boyer</u> M.D.		22b. DATE SIGNED <u>11-27-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>D. J. Boyer, M.D.</u>		22d. ADDRESS <u>136 N. Potomac St. Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/27/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>
24. FUNERAL DIRECTOR <u>Wm. G. Horst</u> <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 30 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Wm. G. Horst</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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16111

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16121

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Washington MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Pen Mar		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Pen Mar	
c. LENGTH OF STAY IN 1b 50 Years		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Leon B. Werdebaugh		4 DATE OF DEATH Month Day Year Nov. 28, 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9/29/1895
9 AGE (In years last birthday) 72 yrs		10 IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Owner		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Waynesboro Pa.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Harry S. Werdebaugh		14 MOTHER'S MAIDEN NAME Laura D. Greenwood	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes World War 2		16 SOCIAL SECURITY NO 217-32-5447A	
17 INFORMANT Harry T. Werdebaugh, 543 Lincoln Way East, Chambersburg Pa.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary Atherosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Two years 88 years		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1, 1950, to Nov 28, 1967 that (I) (we) last saw the deceased alive on Nov 27, 1967, and that death occurred at 9:30 PM, from causes and on the date stated above.			
22a. SIGNATURE Robert A. Kiefer		22b. DATE SIGNED 28 Nov '67	
22c. PHYSICIAN'S NAME (Type) Robert A. Kiefer		22d. ADDRESS Blue Ridge Summit, Penna	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/1/67	
23c. NAME OF CEMETERY OR CREMATORY Harbaugh's		23d. LOCATION (City or Town) (County) (State) Washington Twp., Franklin Pa.	
24 FUNERAL DIRECTOR Walter Y. Grove		25a. REC'D BY REGISTRAR NOV 30 1967	
25b. REG. STR.'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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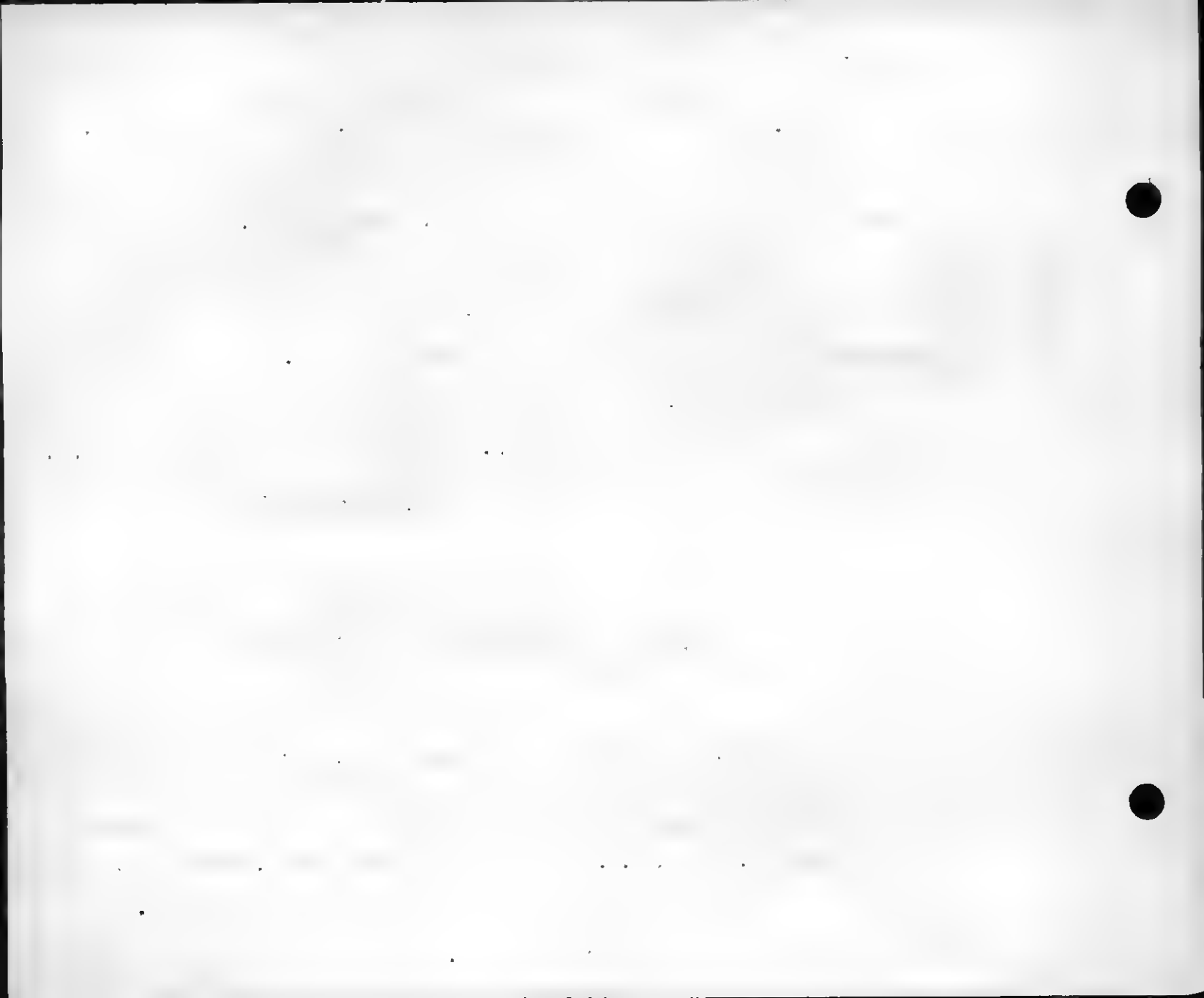
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15122

16112

1. PLACE OF DEATH a. COUNTY Wash. MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY in 49 Years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Jackson Convalescent Home				d. STREET ADDRESS 29N. Colonial Dr.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Idella Middle Violet Last Whipp				4. DATE OF DEATH Month November Day 9 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-21-1909	9. AGE (In years last birthday) 58 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) Berryville, Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frederick Morris				14. MOTHER'S MAIDEN NAME Ann Barr			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-09-3169		17. INFORMANT Address Mr. Richard Whipp, Middletown N.J.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fibillary Astrocytoma, metastatic to Brain & Gcs DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 6 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Adenocarcinoma of Rt. Breast - 3 years							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-10 , 19 61 , to 11-10 , 19 67 , that (I) (we) last saw the deceased alive on 11-10 , 19 67 , and that death occurred at 3 A. M., from causes and on the date stated above.							
22a. SIGNATURE Dalton M. Welty				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 11/10/67	
22c. PHYSICIAN'S NAME (Type) Dalton M. Welty, M.D.				22d. ADDRESS 998 Potomac Avenue, Hagerstown, Maryland			
23a. BURIAL, CREMATION, REMOVA. (Specify) Burial		23b. DATE THEREOF 11-11-67		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City or town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR ADDRESS Minnich Funeral Home, Hagerstown, Md.				25a. REC'D BY REGISTRAR DATE NOV 13 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16123

16113

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 41 Yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 957 Linwood Rd.			
3. NAME OF DECEASED (Type or print) First Middle Last Fred Carr Wilhide				4. DATE OF DEATH Month Day Year November 14, 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 23, 1899	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days 4 21	IF UNDER 24 HRS. Hours Min. 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman			10b. KIND OF BUSINESS OR INDUSTRY Dairy		11. BIRTHPLACE (County & State, or foreign country) Keedysville, Md.		
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME John D. Wilhide				
14. MOTHER'S MAIDEN NAME Alice Knadler			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.				
16. SOCIAL SECURITY NO. 214-09-8557			17. INFORMANT Mrs. Mary F. Wilhide, 957 Linwood Rd.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor Pulmonale due to Emphysema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive C-V. Disease DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 1961 1961	
PART II. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from April 29, 1961 to Nov 14, 1967 , that (I) (we) last saw the deceased alive on Nov 14, 1967 , and that death occurred at 3:20 PM , from causes and on the date stated above.							
22a. SIGNATURE Sidney Hoveston		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11-15-67			
22c. PHYSICIAN'S NAME (Type) SIDNEY HOVESTON		22d. ADDRESS FUNKSTOWN MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-17-67	23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		23d. LOCATION (City or Town) (County) (State) Keedysville, Md.			
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.				25a. REC'D BY REGISTRAR NOV 21 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15113

15113

Washington

Washington

Washington

Washington

921 Lincoln St.

Washington County Hospital

Washington County Hospital

Washington County Hospital

March 13, 1933

March 13, 1933

Washington, D.C.

Washington, D.C.

John D. Williams

John D. Williams

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington County Hospital
Washington, D.C.

Washington

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16124

CERTIFICATE OF DEATH

16114

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 40 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 335 N. Potomac St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Coffman Home for the Aging		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emma Middle Blanche Last Wolfkill		4. DATE OF DEATH Month November Day 30 , Year 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-23-88
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 7 Days 21 Hours 1 Min.	11. IF UNDER 24 HRS. Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Walnut Bottom, Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Eber Naugle		14. MOTHER'S MAIDEN NAME Sadie Ingram	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Ronald Miller, Hagerstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis generalized DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH undetermined	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Glaucoma, cataract		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour pm 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-29, 1959 to death , that (I) (we) last saw the deceased alive on 5-4 1967 , and that death occurred at 10:30 A.M. from causes and on the date stated above.			
22a. SIGNATURE Robert F. Keadle M.D.		22b. DATE SIGNED 12-1-67	
22c. PHYSICIAN'S NAME (Type) ROBERT F. KEADLE		22d. ADDRESS Hagerstown Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-2-67	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE DEC 5 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			

